

## CERTIFICATE OF DEATH

03004

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Queens</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>		c. LENGTH OF STAY IN lb <b>3 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York Flushing</b>		d. STREET ADDRESS <b>43-57 Union St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Office of Dr. Wilson and Dr. Wirth</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sherman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, '21</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>45</b> Days <b>45</b> Hours <b>45</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham</b>		14. MOTHER'S MAIDEN NAME <b>Anna J.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Harold Ader</b>		Address <b>340 W. 28 St. N.Y.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertensive cardiovascular disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/26/67</b>	20f. (City or town) (County) (State) <b>3/26/67</b>
21. I certify that (I) (we) attended the deceased from <b>10:00 AM</b> , to <b>12:00 noon</b> , that (I) (we) saw the deceased alive on <b>3/26/67</b> , 19 <b>67</b> , and that death occurred at <b>12 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Charles H. Wirth</b>		22b. DATE SIGNED <b>3/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Wirth, M.D.</b>		22d. ADDRESS <b>Lothian, Maryland, 20820</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 27, 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron</b>	23d. LOCATION (City or Town) (County) (State) <b>Flushing NY</b>
24. FUNERAL DIRECTOR <b>Thomas A. Hardisty</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1967</b>	
ADDRESS <b>Galesville, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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## CERTIFICATE OF DEATH

030023

03005

1. PLACE OF DEATH a. COUNTY <u>ANNIE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>4 weeks.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 DONCASTER CT</u>	
d. STREET ADDRESS <u>5416 Rotherian Rd, Balto.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET CHARNOCK ANDREWS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-MOTHER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>NORTHAMPTON, VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE H. CHARNOCK</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HAMILTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-28783</u>	
17. INFORMANT Address <u>Mrs. Lucil HAMLET, as under-1 d.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4331</u> IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO (b) <u>Rapid Atrial Fibrillation</u> DUE TO (c) <u>Advanced Art. Scler. Card. Vasc. Disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Left lower lobe pneumonia. Old C.V.A.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> , to <u>3/22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Peter F. Verkouuw</u>		22b. DATE SIGNED <u>3/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER F. VERKOUW</u>		22d. ADDRESS <u>1407 Forest Drive, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cape Charles Northampton Va.</u>
24. FUNERAL DIRECTOR <u>George H. Wilkins</u>		25a. REC'D BY REGISTRAR <u>CHAR 27 1967</u>	
ADDRESS <u>Cape Charles, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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PERMITS OF MARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03014					03006				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>922 Langley Road</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last <u>B. ASHMENSKAS</u>					4. DATE OF DEATH Month <u>3</u> - Day <u>26</u> - Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH (1891) <u>Nov. 8, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Western MD. RR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lith.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. MORIE KUCHER - 922 Langley Rd - GB</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Cerebral Arteriosclerotic Disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>March</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb</u> , 19 <u>67</u> , and that death occurred at <u>                    </u> M., from causes and on the date stated above.									
22a. SIGNATURE <u>Mario J. Reda</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARIO J. REDA MD.</u>					22d. ADDRESS <u>4016 RITCHIE HWY BALTO 21225</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Brooklyn 25, MD.</u>		
24. FUNERAL DIRECTOR <u>John H. Hahn Funeral Home</u>					ADDRESS <u>4200 Pennington Ave</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



03000

OFFICE OF DEATH





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**03015**

## CERTIFICATE OF DEATH

**03007**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN lb <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <u>21061</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				d. STREET ADDRESS <u>7021 Cresthaven Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Billy F. Avery</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>12</u> Year <u>1967</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>10-3-30</u>		
9. AGE (In years lost birthday) <u>36 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>United State</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Arundel High Sch.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		
13. FATHER'S NAME <u>Frederick Avery</u>				14. MOTHER'S MAIDEN NAME <u>Katie Warwick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>xxxxxx</u> <u>Korean War</u>				16. SOCIAL SECURITY NO. <u>244-44-3357</u>		17. INFORMANT <u>Martha E. Avery (wife) same as above</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5870</u> IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-67</u> , 19 <u>67</u> to <u>3-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-11-67</u> , 19 <u>67</u> , and that death occurred at <u>9:54</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Charles R. MacDonald</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-12-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>				22d. ADDRESS <u>P.O. Box 700, Glen Burnie, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore County</u>		
24. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD FUNERAL HOME</u>				ADDRESS <u>4107 Wilkens Ave.</u>		25a. REC'D BY REGISTRAR <u>MAR 17 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03007

STATEMENT OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03008

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>/////</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ritchie Hgts, Pasadena</b> 02-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>			d. STREET ADDRESS <b>Route 9, Box 342</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WALTER BECKETT</b>			4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1888</b> 79 yrs.		9. AGE (In years last birthday) <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of previous year, even if retired) <b>Painter (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Davidson Chemical</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William Beckett</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Berger</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>217-14-6794</b>		17. INFORMANT <b>Mrs Louisa E. Beckett (wife) Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple severe injuries</b> DUE TO (b) <b>8124</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by car</b>			
20c. TIME OF INJURY Month, Day, Year <b>7:10 p.m. 3-24 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
				20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>3-25-67</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 29, 1976</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



0300

0300

Richard V. Singleton  
Morton 27, 12, 1985  
Morton 27, 12, 1985



03017

## CERTIFICATE OF DEATH

03009

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>4 mon. 6 das.</u>		d. STREET ADDRESS <u>1322 N. Caroline Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33674 <u>Walter Berry</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/29/94</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Berry</u>		14. MOTHER'S MAIDEN NAME <u>Ennings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Organizing Bronchopneumonia, marked both lobes</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>-----</u> (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/26/1966</u> , to <u>3/6/1967</u> , that (I) (we) last saw the deceased alive on <u>3/6/1967</u> , and that death occurred at <u>3:30 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>C. Dorkan</u>		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Dorkan, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>5501 Fred'k Ave Md.</u>	
24. FUNERAL DIRECTOR <u>Elliot Funeral Home, N. Carolina</u>		25a. REC'D BY REGISTRAR <u>1129</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 16 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05030

1900

At last night 10/11/1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03018

CERTIFICATE OF DEATH

03010

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		d. STREET ADDRESS <u>1400 ISTD RD</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA EDNA BESTE</u>		4. DATE OF DEATH <u>MARCH 1 19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E GROOMS</u>		14. MOTHER'S MAIDEN NAME <u>JOANNA REDDISH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>HARRY A. BESTE</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Head of Pancreas</u> DUE TO (b) <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Interval between onset and death</u> DUE TO (c) <u>Interval</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>64</u> to <u>3/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>67</u> , and that death occurred at <u>8:57</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD I. HOCHMAN</u>		22d. ADDRESS <u>59 FRANKLIN ST. ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-4-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN AA Co MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOLIS MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 6 1967</u>			



03010  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 DEATH CERTIFICATE  
 No. 10  
 Name of Deceased: **WILLIAM E. GROOMS**  
 Sex: **Male**  
 Date of Birth: **Dec. 21, 1880**  
 Place of Birth: **Clarke Co., Md.**  
 Date of Death: **March 1, 1900**  
 Cause of Death: **Heart Disease**  
 Physician: **Dr. J. H. [illegible]**  
 Burial Place: **St. Ann's Cemetery, Baltimore, Md.**  
 Name of Undertaker: **Richard I. Hochman**  
 Signature of Registrar: **[illegible]**  
 Date of Registration: **March 1, 1900**



## CERTIFICATE OF DEATH

03011

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr. 2 mos.</u>		d. STREET ADDRESS <u>531 N. Patterson Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #34412 <u>Samuel</u> <u>Bivens</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/1881</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-5047</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolism (?)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>026X (c)</u> (b) <u>Ca of the Prostrate</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.N.S. Syphilis Latent : Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/</u> , 19 <u>66</u> , to <u>3/1/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/1/</u> 19 <u>67</u> , and that death occurred at <u>6:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles A. Rice 661 W. Barre St.</u>		25a. REC'D BY REGISTRAR <u>MAR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**03020**

## CERTIFICATE OF DEATH

**03012**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>6914 George Palmer Highway</b>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>David</b> Last <b>BLACKWELL, III</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1966</b>
9. AGE (In years lost birthday) yrs. <b>6</b> Months <b>13</b> Days <b>13</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Andrew David Blackwell, jr</b>		14. MOTHER'S MAIDEN NAME <b>Duling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Andrew David Blackwell Jr.</b>		Address <b>Seat Pleasant Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumothorax</b> DUE TO (b) <b>Bronchiolitis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Feb. 25</b> , 19 <b>67</b> , to <b>Mar. 1</b> , 1967, that (I) <del>(we)</del> last saw the deceased alive on <b>Mar. 25</b> , 1967, and that death occurred at <b>4:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Antonio M. Rivera</i>		22b. DATE SIGNED <b>2 Mar 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonio M. Rivera, M.D.</b>		22d. ADDRESS <b>SouthRivMedCent., Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/4/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.



03018

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03021

03013

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis, M</b> c. LENGTH OF STAY IN 1b <b>12-1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b> d. STREET ADDRESS <b>Box 638 Rt. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b> First <b>B. M.</b> Middle <b>Blair</b> Last (A.K.A.) <b>Michael</b>				4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 27, 1898</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Millright(ret.) Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Sharon, Pa.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Millright(ret.) Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Sharon, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Simmon Blair</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Blaga</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>209-05-1098A</b>			
17. INFORMANT <b>Mrs. Catherine L. Blair</b>				Address <b>same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause</b> <b>4344</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>[Signature]</b> EXAMINER'S NAME (Type) <b>F. Linhardt</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>March 6, 1967</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b> 22d. LOCATION (City, town, or country) (State) <b>Baltimore Maryland</b>							
23. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> Hopping Funeral Home				24. REC'D BY REGISTRAR <b>MAR 6 1967</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

DATE SIGNED

3/1/67



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03022

03014

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>ANNAPOLIS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>H.A. GENERAL Hospt.</b>		d. STREET ADDRESS <b>433 4th St.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN A. BLOXOM</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>	
13. FATHER'S NAME <b>PERRY LEE BLOXOM</b>		14. MOTHER'S MAIDEN NAME <b>DAMYE PARKS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or notes of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>PRESTON K. BLOXOM</b>	
17. INFORMANT <b>7828 HIGH POINT RD BALTIMORE MD</b>		18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis femoralis</b> DUE TO (b) <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. Linhart</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>3/21/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/23/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>MARTINSBURG W. VA.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR - SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION



John M. Taylor & Associates Md.  
Burial 3/23/1972 Reston Cem. Martinsburg W. Va.

Richard  
Taylor

Yes WWII

Berry Lee Bloom

Damye Parks

Hotel

Bloom Virginia U.S.A.

Male White

8-19-1897

A.

Bloom

March 21

A.A. General Hospit.

438 4th St.

Annapolis

Annapolis

A.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03023

CERTIFICATE OF DEATH

03015

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b>		c. LENGTH OF STAY IN 1b <b>45 MINUTES</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UPPER MARLBORO</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>			d. STREET ADDRESS <b>RED BOX 3429</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARVIN</b> Middle <b>WADE</b> Last <b>BOSTIC</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>31</b> Year <b>19 67</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Nov 1965</b>		9. AGE (In years last birthday) <b>1</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel, Maryland</b>	
13. FATHER'S NAME <b>CHARLES S. BOSTIC</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>N/A</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (mother) Address <b>Mrs. Fredia Bostic, 3429 Upper Marlboro, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>872.9</b> DUE TO <b>Gross Anatomical findings consistent with</b> (b) <b>Salicylate Intoxication</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED <b>3</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>31 Mar</b> , 19 <b>67</b> , to <b>31 Mar</b> , 19 <b>67</b> that <del>he</del> (we) last saw the deceased alive on <b>31 Mar</b> , 19 <b>67</b> , and that death occurred at <b>7:50 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Robert F. Cullen, Jr.</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>31 March 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>ROBERT F. CULLEN, JR., MC</b>			22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24a. FUNERAL DIRECTOR <b>Beverly E. Hopping</b> <b>HOPPING FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>APR 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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## CERTIFICATE OF DEATH

03016

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>O.O. A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>200 E/ Benton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LOUIS</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Aug. 1905</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A.A. Co. Police Dept</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lansdowne, Maryland</b>	
13. FATHER'S NAME <b>William L. Brown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>014-22-2665</b>		17. INFORMANT <b>Mr. George Brown</b> Address <b>3241 Ryerson Circle - Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Atherosclerosis, generalized</b> DUE TO (c) <b>10 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> , 19 <b>66</b> , to <b>12-18</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12-18</b> , 19 <b>66</b> , and that death occurred at <b>2:47 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>George H. Yeager</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar 28, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>George H. Yeager</b>		22d. ADDRESS <b>University Hosp. Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/30/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Brooklyn, R.F.O. Md.</b>	
24. FUNERAL DIRECTOR <b>Singleton Funeral Home/ Glen Burnie, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 29 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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03025

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN lb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>2 Hull Avenue, Bay Ridge</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Madeline BUCKLEY</b>				4. DATE OF DEATH Month Day Year <b>March 4 1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1884</b>		9. AGE (In years last birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Maurice Buckley</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Boright</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-44-0419T</b>		17. INFORMANT <b>Miss May B. Eastman</b> Address <b>same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>U Rem A</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>physician</del> attended the deceased from <b>MAY 10, 1962</b> to <b>March 4, 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>3 MARCH 1967</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Edward S. Beck</b> M.D.				22b. DATE SIGNED <b>3:50 am</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>	
22d. ADDRESS <b>73 Franklin St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE THEREOF <b>Mar. 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>		23d. LOCATION (City or Town) (County) (State) <b>Olney Richland Ill.</b>	
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> <b>HOPPING FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>Beverley E. Hopping</b> <b>Annapolis, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>MAR 7 1967</b>			



03017

EXHIBIT OF CLAIM

03017

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03026

## CERTIFICATE OF DEATH

03018

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN lb <u>1 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor</u>		d. STREET ADDRESS <u>(Rural)</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Katherine Marie Burkman</u>		4. DATE OF DEATH <u>March 11 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 26 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Christian Rausch</u>	
14. MOTHER'S MAIDEN NAME <u>Mae Listman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>350X</u>		17. INFORMANT <u>Henry Henry Burkman</u> Address <u>Port Republic, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>parkinsonism</u> DUE TO (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>degenerative arthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>67</u> , to <u>3/4</u> , 19 <u>67</u> that (I) <u>(no)</u> last saw the deceased alive on <u>2/21</u> 19 <u>67</u> , and that death occurred at <u>3:35 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ray M. Smith</u>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M. D.</u>		22d. ADDRESS <u>Hahn Professional Bldg., Md. Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 14 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Port Republic Calvert Md.</u>
24. FUNERAL DIRECTOR <u>A.A. Harkness &amp; Son</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



030192



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03027

CERTIFICATE OF DEATH

03019

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 hr +</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> 16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>Donnell</b> <b>8412 DONNELL Place, Apt-84</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Henderson CHANEY, Jr.</b>			4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1967</b>		9. AGE (In years last birthday) yrs. <b>1</b> <b>35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel, Maryland</b>	
13. FATHER'S NAME <b>George Henderson Chaney</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>776X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 35 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>March 28, 19 67</b> , to <b>March 28, 1967</b> , that (I) <b>(see)</b> lost saw the deceased alive on <b>March 28 19 67</b> , and that death occurred at <b>8:40 PM</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Frank M. Kopack M.D.</b>		22b. DATE SIGNED <b>Mar. 29, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank M. Kopack</b>	
22d. ADDRESS <b>1911 Forest Drive Annapolis Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Chr. Cemetery Owings, Calvert Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

7-275787



03013

REPORT OF DEATH

03013

Place of death

City

State

Age

Sex

Marital status

Date of death

Time of death

Place of death

City

State

Age

Sex

Date of death

Time of death

Place of death

City

State

Age

Date of death

Time of death

Place of death

Signature

Place of death

Place of death

City

State

Date of death

Time of death

Place of death

Signature

Place of death

City

State



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only deputy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/14/67 pc

03028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03020

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH. ARUNDEL - 465 p.</u>		d. STREET ADDRESS <u>2103 Murray Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vergie</u> Middle <u>D</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/66</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>restaurant</u>	11. BIRTHPLACE (State or foreign country) <u>Strausburg, Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Mitchell</u>	
14. MOTHER'S MAIDEN NAME <u>Idie Palmer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>219-32-4252</u>		17. INFORMANT <u>John G. Chaney</u> Address <u>468 Oaktown Ave., Odenton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>582X</u> IMMEDIATE CAUSE (a) <u>Submersion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Hopping</u> M.D.		22. DATE SIGNED <u>3/14/67</u>	
EXAMINER'S NAME (Type) <u>E. Hopping</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Patuxent Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Odenton A.A. Md.</u>
24. FUNERAL DIRECTOR <u>E. Hopping</u> HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



05050

05050

DATE: 10/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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VR A15 (4)  
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
03023															
03021															
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>106 Buckingham Ave</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>106 Buckingham Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Lelah Mae CHORY</b> First Middle Last 4. DATE OF DEATH <b>3 18 1967</b> Month Day Year						5. SEX <b>Female</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept 15, 1895</b> 9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>						11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unk</b>						14. MOTHER'S MAIDEN NAME <b>Unk</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Same</b>	
17. INFORMANT <b>Family</b> Address <b>Same</b>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung. (2)</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <b>August 1966</b> to <b>March 1967</b> , that (I) (we) last saw the deceased alive on <b>3-14-1967</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Charles R. MacDonald MD</b>						22b. DATE SIGNED <b>3-18-67</b>									
22c. PHYSICIAN'S NAME (Type) <b>Charles R. MacDonald</b>						22d. ADDRESS <b>204 Chain Hwy So Glen Burnie Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>				23d. LOCATION (City, town or county) (State) <b>A A Co Md</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>McGully Funeral Home</b>						25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03030

CERTIFICATE OF DEATH

03022

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN lb <b>35 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Box 110</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roman</b> Middle <b>William</b> Last <b>COATES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1905</b>		9. AGE (In years last birthday) yrs. <b>62</b>	IF UNDER 1 YEAR Months <b>22</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Coates</b>				14. MOTHER'S MAIDEN NAME <b>Lavenia White</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No *****</b>		16. SOCIAL SECURITY NO. <b>217-16-3049</b>		17. INFORMANT <b>Lula Price 20 Dorsey Ave, Anna, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4221 DUE TO <b>due to arterio-sclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cardio-Vascular disease</b> (c) <b>Cardio-Vascular disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema of both lungs</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>May 15, 1965</b> , to <b>Mar. 22, 1967</b> , that (I) <b>(see)</b> last saw the deceased alive on <b>Mar. 22, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. L. Richardson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/24/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. L. Richardson, M.D.</b>		22d. ADDRESS <b>110 Clay St., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-25-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carpenters Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Anne Arundel Co, Md</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Annapolis, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



SS030

**Abstract**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03031					03023				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>60 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>4 Riggs Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith I Codd</u>			4. DATE OF DEATH Month Day Year <u>March 5 1967</u>		5. SEX <u>Female</u>				
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1888</u>		9. AGE (In years last birthday) <u>78 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>- Brady</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr. Francis I. Codd - Severna Park, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> DUE TO <u>Cerebrovascular accident</u> DUE TO <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>@ 2 weeks</u> <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>- 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1/3, 1967</u> , to <u>3/5, 1967</u> that (I) (we) last saw the deceased alive on <u>3/5 1967</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Max C Frank MD</u>				22b. DATE SIGNED <u>3/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>			
22d. ADDRESS <u>425 SE Little Hwy Severna Park</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>				25a. REC'D BY REGISTRAR DATE <u>9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
26. SIGNATURE OF REGISTRAR <u>ROBERT S. BARRANCO</u>									



2000



03032

## CERTIFICATE OF DEATH

04545

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>20 Years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) #10436 <u>Manuel</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>- - 90</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Hospital Records</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>R. Lobar Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration, Emaciation, Arteriosclerosis (Generalized)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>47</u> , to <u>3/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/25/ 1967</u> , and that death occurred at <u>9:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>3/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>4/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins School of Med. Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. Reese 108 Washington St. Crownsville, Md.</u>		25a. RECEIVED BY REGISTRAR <u>APR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



6220

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03033

CERTIFICATE OF DEATH

03024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
JOHN HENRY CORDES		3/25/67 12:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION NR. BROOKLYN 331 ORCHARD AVENUE		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. STREET ADDRESS 331 ORCHARD AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/15/1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMAN	10B. KIND OF BUSINESS OR INDUSTRY U.S. POST OFFICE	9. AGE (In years last birthday) 72	11. BIRTHPLACE (State or foreign country) NEW YORK
13. FATHER'S NAME JOHN P. CORDES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 087 30 6328	
17. INFORMANT Mrs. Catherine Leschowsky 331 Orchard Ave.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis (B) DUE TO Generalized arteriosclerosis (C) DUE TO	
21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years (on the 4th Summer Treatment)	
22. I certify that (I) (this hospital) attended the deceased from 3-25 1967 to 3-25 1967 that (I) (we) last saw the deceased alive on 3-25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED 3-27-67	
23A. SIGNATURE Pedro S. de Borja M.D.		23C. PHYSICIAN'S NAME (Type) PEDRO S. DE BORJA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/29/67	
24C. NAME OF CEMETERY or CREMATORY Long Island National		24D. LOCATION (City, town, or county) (State) Farmingdale, New York	
25A. DATE REC'D BY HEALTH DEPT. MAR 30 1967		25B. NAME OF REGISTRAR Oscar O...	
25C. FUNERAL DIRECTOR MacP...		25D. ADDRESS 237 Latona Ave. Balto	







# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G387 3/30/67 pc

FOR STATE HEALTH DEPT.

03034

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03025

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Alto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1111</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shen Burnie - 02-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North. ACUNDEL. Hospital.</u>				d. STREET ADDRESS <u>101-2nd St. St. Paul</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Crigger</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-85-84</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Royal Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>(unknown) Crigger</u>				14. MOTHER'S MAIDEN NAME <u>(unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS Georgia Crigger (Wife)</u> as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caudate disease</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		M.D.		22. DATE SIGNED <u>3/16/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chen Haven Mem Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Chen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>E. B. Fleming</u>				ADDRESS <u>Singheton Funeral Home Chen Burnie</u>		25a. REC'D BY REGISTRAR <u>28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



68082

68082





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03035

CERTIFICATE OF DEATH

03026

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> 021	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1219 McKinley St.,</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank (none) DAVIDSON</b>		4. DATE OF DEATH Month Day Year <b>March 23 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1899</b>
9. AGE (In years last birthday) yrs. <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM DAVIDSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war, dates of service) <b>YES WW I + II</b>		16. SOCIAL SECURITY NO. <b>21405 2543</b>	
17. INFORMANT <b>FREDA G. DAVIDSON #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral of lung (bronchus).</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(do not)</del> attended the deceased from <b>March 19 67</b> , to <b>Mar. 23, 19 67</b> that (I) <del>(do not)</del> saw the deceased alive on <b>March 23, 19 67</b> , and that death occurred at <b>1:00 PM</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Genaro Citronell</b>		22b. DATE SIGNED <b>3/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>General Blumel</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-25-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR-SONS ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



03030

RECEIVED BY MAIL

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03036

CERTIFICATE OF DEATH

03027

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Samuel Kemp DAWSON</b>		4. DATE OF DEATH <b>March 4, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 April 1875</b>
9. AGE (In years last birthday) yrs. <b>91</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Churchton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William DAWSON</b>		14. MOTHER'S MAIDEN NAME <b>SIMMONS, Margaret Rebecca</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>216 18 5782</b>	
17. INFORMANT <b>Katherine Gomoljak, 179 Defense Hgwy</b>		Address <b>Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram-negative septicemia</b> DUE TO (b) <b>Chronic pyelonephritis</b> DUE TO (c) <b>Benign prostatic hypertrophy</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>? years</b> <b>? years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cancer of stomach, Inanition due to pyelonephritis and carcinoma, Arteriosclerosis, Anemia due to cancer of stomach with hemorrhage</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>21 December 1966</b> , to <b>4 March 1967</b> , that (I) (we) last saw the deceased alive on <b>4 March 1967</b> , and that death occurred at <b>10:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>4 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wood Field</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville, Md</b>	
24. FUNERAL DIRECTOR <b>T A Hordley, Galesville, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03023

INSTITUTE OF HEALTH

James Brundage

Mar 1 1913

James Brundage

James Brundage (Jr.)

James Brundage

James Brundage

James Brundage (Jr.)

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03037					03028				
CERTIFICATE OF DEATH					CERTIFICATE OF DEATH				
1. PLACE OF DEATH a. COUNTY <b>AnneArundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					d. STREET ADDRESS <b>240 B. Hilltop Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clara Francis DIMAGGIO</b>					4. DATE OF DEATH Month Day Year <b>March 9 19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 5, 1912</b>		9. AGE (In years lost birthday) yrs. <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BANKING</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN WILKIE SR.</b>					14. MOTHER'S MAIDEN NAME <b>RUTH BREWER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>218 285478</b>		17. INFORMANT <b>ALBINO M. DiMaggio</b> Address <b>#2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular disease</b> DUE TO (b) <b>Cerebral disease &amp; myocardial infarct</b> DUE TO (c) <b>Years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <b>physician</b> attended the deceased from <b>2/9</b> , 19 <b>67</b> , to <b>Mar. 9</b> , 19 <b>67</b> , that (I) <b>did</b> last saw the deceased alive on <b>Mar. 9</b> , 19 <b>67</b> , and that death occurred at <b>8:05 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>General Church</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>3/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>General Church</b>					22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>			23d. LOCATION (City or Town) (County) (State) <b>ANNAPODIS A.A. MD.</b>		
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



03052

no  
John Willie Sr.  
FATH BREWER  
BANK  
HUNAPOLIS

2-13-17 St Marys  
 John W. Johnston (Chicago, Ill.)  
 1861  
 Annapolis A. A. M.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03038

03029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - near Curtis Bay ~ 15 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge, 27</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dispensary, Coast Guard Yard</b>		d. STREET ADDRESS <b>5608 Washington Blvd</b>	
3. NAME OF DECEASED (Type or print) <b>Harry Emory</b>		4. DATE OF DEATH <b>March 13 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-1907</b>
9. AGE (In years last birthday) <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Newport News Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mitchell Emory</b>		14. MOTHER'S MAIDEN NAME <b>MARY WATTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-1677</b>	
17. INFORMANT <b>MRS FRANCES EMORY</b>		Address <b>Elkridge 5608 Wash. Blvd 27md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Probable myocardial infarction manifest as cardiac arrest</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 30 1946</b> to <b>March 13, 1967</b> , that (II) (we) last saw the deceased alive on <b>March 13, 1967</b> , and that death occurred <b>8 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Lacher</b>		22b. DATE SIGNED <b>March 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John W. Lacher, M.D.</b>		22d. ADDRESS <b>Curtis Bay Coast Guard Yard, 21226</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>	23d. LOCATION (City, town or county) (State) <b>Elkridge, md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Higginbotham</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 17 1967</b>	



03050

CERTIFICATE OF DATA

03050

1. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

2. Title of the report: *Medical History of a Soldier*

3. Name of the person or organization to whom the report is made: *U.S. Army Medical Department Center and School*

4. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

5. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

6. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

7. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

8. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

9. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

10. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

11. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

12. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

13. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

14. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

15. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

16. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

17. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*

18. Name of the person or organization making the report: *U.S. Army Medical Department Center and School*



FOR STATE  
HEALTH DEPT.

03039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03030

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 MARKET ST.</u>		e. STREET ADDRESS <u>112 MARKET ST</u>	
3. NAME OF DECEASED (Type or print) <u>MARION H. ESTABROOK</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1908</u> 9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>FRANK HARTLEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA DUCKWORTH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARION H. WAHL BLOOMFIELD N.J.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Suba</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linbrook</u> M.D.		22. DATE SIGNED <u>3/2/67</u>	
EXAMINER'S NAME (Type) <u>F. Linbrook</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BREMOVAL</u>	23b. DATE THEREOF <u>3-3-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PORT LINCOLN</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEO. Co. MD</u>
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



05050

05050

ST. MARKET ST.

ST. MARKET ST.

FRANK HARTLEY

RECEIVED 3-3-11

RECEIVED 3-3-11



03040

## CERTIFICATE OF DEATH

03031

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>4 Luna Lane</b>	
3. NAME OF DECEASED (Type or print) #34888 First Middle Last <b>Roland Street Fiske</b>		4. DATE OF DEATH Month Day Year <b>3 20 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/91</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>20 1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVT.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marston Fiske</b>		14. MOTHER'S MAIDEN NAME <b>Galloway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>218-149-7201</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with Generalized Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/13/</b> , 19 <b>67</b> , to <b>3/20/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/20/</b> , 19 <b>67</b> , and that death occurred at <b>10:10 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M.D.</b>		22b. DATE SIGNED <b>3/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>Charles S. Bonner</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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STATE OF TEXAS

03050

JAN 1 1965



03041

## CERTIFICATE OF DEATH

03032

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN lb <u>45yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <u>02-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>95 Glendale Ave.</u>				d. STREET ADDRESS <u>95 Glendale Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>J.</u> Last <u>Flannery</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Paint Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael J. Flannery</u>				14. MOTHER'S MAIDEN NAME <u>Ella Gerlach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-3614</u>		17. INFORMANT Address <u>Same as</u> <u>Mrs. Dorothy A. Flannery (Wife)</u> #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO <u>Arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> , to <u>2-10-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-1-</u> 19 <u>67</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Ignas Saulynas</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ignas Saulynas, M.D.</u>				22d. ADDRESS <u>319 Old Annapolis Rd. Ferndale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Eugene B. Flannery</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Singleton Funeral Home Glen Burnie, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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03042

## CERTIFICATE OF DEATH

03033

1. PLACE OF DEATH a. COUNTY <b>ANN ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANN ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. LENGTH OF STAY IN 1b <b>PASADENA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>224 BAR HARBOR ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Danial E Follin</b>		4. DATE OF DEATH Month Day Year <b>3 14 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/1911</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES E. FOLLIN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE BRENDLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS GRACE FOLLIN</b>		Address <b>224 BAR HARBOR RD. PASADENA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Previous Coronary Thrombosis 1 year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> to <b>March</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>3/12/67</b> , 19 <b>67</b> , and that death occurred at <b>7:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Isaac Miller M.D.</b>		22b. DATE SIGNED <b>3/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR ISAAC MILLER</b>		22d. ADDRESS <b>1225 So Charles St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>GLEN BURNIE AA MD.</b>
24. FUNERAL DIRECTOR <b>McCULLY F.H.</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



34334

UNITED STATES

DEPARTMENT OF

ARMY

OFFICE OF

CHIEF OF BUREAU

WASHINGTON, D.C.

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DATE: /

BY: /

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03043

CERTIFICATE OF DEATH

03034

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. LENGTH OF STAY IN TB <u>2 1/2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Boone Trail</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY A. GARTLAND</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>15</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-84</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BARTH S. CRONIN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET KIDNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Timothy Malone Aboue</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kidney Calculi</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>64</u> , to <u>Mar.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar. 13</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Francis I. Codd</u>		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>		22d. ADDRESS <u>Severna Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, Kings, N.Y.</u>
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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HONOLULU, HAWAII



FOR STATE  
 HEALTH DEPT.

03044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03035

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			c. LENGTH OF STAY IN 1b <b>///////</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> <b>12-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Anne Arundel Hospital</b>				d. STREET ADDRESS <b>133 Dorechester Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ethel M. George</b>				4. DATE OF DEATH <b>March 18 19 67</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 21, 1899</b>		
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(unknown) Riebert</b>				14. MOTHER'S MAIDEN NAME <b>(Unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. William R. George (Son) Same as #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>xxx</b> (by exclusion) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)		22. DATE SIGNED <b>March 19, 1967</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk. Glen Burnie, Md.</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>				25a. REC'D BY REGISTRAR <b>Mar 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



3308



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03045

## CERTIFICATE OF DEATH

03036

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>2423 E. Fayette Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>#34883 Carl Gibson</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>21</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/7/26</u>	
9. AGE (In years last birthday) <u>41 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Ed Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Annie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Chronic Alcoholism</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour am p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/12/</u> , 19 <u>67</u> , to <u>3/21/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/21/</u> , 19 <u>67</u> , and that death occurred at <u>12:50</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>JELICO CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>JELICO, TENNESSEE</u>	
24. FUNERAL DIRECTOR <u>Stanley Miller - 2334 Jefferson St</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



03032

CERTIFICATE OF DEATH

03032

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
New York		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Age at Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
60		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
12/12/1912		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Time of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10:00 AM		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Signature of Physician		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Doe, M.D.		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Signature of Registrar		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Doe, M.D.		12/12/1912		Male		White		Married		Farmer		Heart Disease		Home		12/12/1912		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	

This is to certify that the above is a true and correct copy of the original record as filed in the office of the Registrar of Deaths for the State of New York.



03046

CERTIFICATE OF DEATH

03037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>31 Bay Drive, Bay Ridge</b>	
3. NAME OF DECEASED (Type or print) <b>AKA Bernard Sol Middle Goldstein last MERELMAN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Israel Merelman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Eisler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>W.W. I</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Bernard Legum</b>		18. ADDRESS <b>11 Stehle St., Annapolis, Maryland</b>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Acute coronary thrombosis</b> DUE TO (c) <b>Coronary artery sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>June 10, 1967</b> , to <b>March 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 10, 1967</b> , and that death occurred at <b>9:40 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John L. Hedeman</b>		22b. DATE SIGNED <b>3/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman, M.D.</b>		22d. ADDRESS <b>1407 Forest Drive, Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>
24. FUNERAL DIRECTOR <b>Beverly E. Hopping</b> <b>Hopping Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



03030

2250

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03047

## CERTIFICATE OF DEATH

03038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN Tb <u>30 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30-4</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>#05301 Annie Gray</u>		4. DATE OF DEATH <u>3</u> <u>15</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>-/-/77</u>
9. AGE (In years lost birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Chronic Brain Syndrome secondary Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Chronic Brain Syndrome secondary Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/3/</u> , 19 <u>37</u> , to <u>3/15/1967</u> , that (I) (we) last saw the deceased alive on <u>3/15/1967</u> , and that death occurred at <u>4:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>3-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>108 Wash. St. Annapolis, Md.</u>	



03038

EXHIBIT OF DEATH

03038

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Occupation		Cause of Death	
Manner of Death		Signature of Physician	
Signature of Coroner		Signature of Witness	
Signature of Burial Officer		Signature of Undertaker	
Signature of Registrar		Signature of Clerk	
Signature of Minister		Signature of Chaplain	
Signature of Priest		Signature of Rabbi	
Signature of Imam		Signature of Other	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03048 CERTIFICATE OF DEATH 03039

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. LENGTH OF STAY in lb <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		d. STREET ADDRESS <b>Box 169, Rt. 11</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 169, Rt. 11</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JESSIE GERALDINE GUTBERLET</b>				4. DATE OF DEATH <b>3 16 1967</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb. 28, 1914</b>				9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Springfield, Ill.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>Clifford W. Stone</b>			
14. MOTHER'S MAIDEN NAME <b>----- Slaten</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>233-24-0557</b>				17. INFORMANT <b>Joseph F. Gutberlet (same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>9 YRS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUGUST</b> ....., 19 <b>58</b> , to <b>FED</b> ....., 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>FED 21</b> ....., 19 <b>67</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur Lankford Jr.</b>				22b. DATE SIGNED <b>3-17-67</b>		22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD, JR., M. D.</b>	
22d. ADDRESS <b>2934 Mountain Rd. Pasadena, Md. 21122</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Mar. 20, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



03032

03032

Age 10 years 10 months 10 days

Sex Male Race White Height 5' 10" Weight 150 lbs. Eyes Blue Hair Brown

Birth Date 10/10/1910 Birth Place Baltimore, Md. Education 10 years

Marital Status Single Occupation Clerk of Court

Signature [Signature] Date 10/10/1910

Witness [Signature] Date 10/10/1910

Notary Public [Signature] Date 10/10/1910

County Clerk [Signature] Date 10/10/1910

City Clerk [Signature] Date 10/10/1910

State Clerk [Signature] Date 10/10/1910

U.S. District Court [Signature] Date 10/10/1910



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #7 Film #G387 3/28/67 ps

03043

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03040

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>02-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>360 Gaylor Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>BURNARD</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>Nov 16 - 1909</b>
9. AGE (In years lost birthday) yrs. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Planter</b>	
11. BIRTHPLACE (State or foreign country) <b>Ken</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sam Hammett</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Watkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>225-24-522</b>	
17. INFORMANT <b>Alpha Hammett</b>		Address <b>Sam</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute ethylism</b> 3220 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		22. DATE SIGNED <b>3-25-67</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Caren Memorial Cat</b>	23d. LOCATION (City or Town) (County) (State) <b>Louisa Md</b>
24. FUNERAL DIRECTOR <b>Elroy A. Wilson 1000 Brantley Ave</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



03048

03048

03048

MAR 21 1964



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03050

## CERTIFICATE OF DEATH

03041

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>1 mo. 1 da.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>
d. STREET ADDRESS <b>Rt-2, Box-405</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>Minnie</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1900</b>		9. AGE (In years last birthday) yrs. <b>66</b>	10. IF UNDER 1 YEAR Months <b>66</b>	11. IF UNDER 24 HRS. Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Martin</b>				14. MOTHER'S MAIDEN NAME <b>Alice Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wilfred Pulley Anna M.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral</b> <b>443X</b> DUE TO <b>chronic Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertension causes Cerebral Disease</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>2-17-67</b> , to <b>Mar. 3, 1967</b> that (I) (we) saw the deceased alive on <b>Mar. 3, 1967</b> , and that death occurred at <b>2:55 PM</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Allen</b>				22b. DATE SIGNED <b>3-4-67</b>		22c. PHYSICIAN'S NAME (Type) <b>A T ALLEN</b>	
22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-7-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		23d. LOCATION (City or town) (County) (State) <b>St. Margaret, Md.</b>	
24. FUNERAL DIRECTOR <b>William Reese</b>				25a. REC'D BY REGISTRAR <b>MAR 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



0330

CERTIFICATE OF DEATH

03001

Form with multiple sections and fields, including a large rectangular area in the center and a circular stamp on the right side. The text is mostly illegible due to fading and bleed-through.

03001



03051

## CERTIFICATE OF DEATH

03042

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beach 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville St. Hospital</u>		d. STREET ADDRESS <u>14-2</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT C. HAYNES</u>		4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-30</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ellery Haynes</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Zennes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-1255</u>	
17. INFORMANT <u>Mrs. Elizabeth D. Haynes</u>		Address <u>2644 73rd Place Kent Village, Md.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure,</u> 410X DUE TO <u>Rheumatic heart, Aortic insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>coronary stenosis &amp; coronal insuff.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/31/67</u> , 19 <u>67</u> , to <u>5/10/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/10/67</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. BENEDICT M.D.</u>		22b. DATE SIGNED <u>5/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Crownsville State Hosp</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Southern Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Dunkirk Calvert Md.</u>
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
ADDRESS <u>Owings, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03003

DEPARTMENT OF HEALTH

03003

03003

Number

Elmer, Haven

No

100-10000 Mrs. Elizabeth D. Haven

Washington, D. C.

Married name

3814 10th place

Rock Hill, S. C.

Mar. 18, 1907

Mar. 18, 1907

Mar. 18, 1907

Mar. 18, 1907



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03052

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03043

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARNESS CREEK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>Rt D #3</u>	
3. NAME OF DECEASED (Type or print) <u>FRITZ LEE HENKENSIEKEN</u>		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1911</u>
9. AGE (In years) <u>56</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDER</u>	
11. BIRTHPLACE (State or foreign country) <u>HUMBOLDT, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY HENKENSIEKEN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH RICHARDSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>220 07 0847</u>	
17. INFORMANT <u>SARAH H. BROWN #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> DUE TO (b) <u>Surden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>4344</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>3/27/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.H. MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



08049

08049

10/10/12

10/10/12

10/10/12

10/10/12



03053

CERTIFICATE OF DEATH

Reg. Dist. No.

03044

1. PLACE OF DEATH a. COUNTY <u>AA</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
c. LENGTH OF STAY IN 1b <u>D.O.S.</u>		d. STREET ADDRESS <u>Box 68 Rt 5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Central Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>G</u> Last <u>Henley</u>		4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-99</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>	IF UNDER 24 HRS. Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Rufus Trumpton</u>	
14. MOTHER'S MAIDEN NAME <u>Elise Barst</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213 201362</u>		17. INFORMANT <u>John Henley (Living)</u> Address <u>Smith, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YRS.</u> <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>60</u> , to <u>MARCH</u> , 19 <u>67</u> , that I lost saw the deceased alive on <u>MARCH 2</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>2934 MOUNTAIN ROAD PASADENA, MD. 21122</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD, JR., M.D.</u>		DATE SIGNED <u>3-12-67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-15-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u> ADDRESS <u>Severna Park</u>		24. BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 14 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03054					03045						
1. PLACE OF DEATH a. CDUNITY <b>Anna Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8445 Bay Rd</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>A A Co</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b> d. STREET ADDRESS <b>8445 Bay Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Myrtle</b> First <b>O</b> Middle <b>Herberson</b> Last			4. DATE OF DEATH <b>Mar</b> Month <b>23</b> Day <b>19</b> Year <b>67</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct 25, 1892</b>		9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Va</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Lewis Ellis</b>					14. MOTHER'S MAIDEN NAME <b>Georgianna</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address <b>Same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes mellitus</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic vascular</b> DUE TO (c) <b>dream</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Aug 1947</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>62</b> , to <b>3/23/67</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> 19 <b>67</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert Dabelias</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-24-67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Robert Dabelias, M.D.</b>					22d. ADDRESS <b>400 Crown Henry Rd. Silver Spring, Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			23d. LOCATION (City, town or county) (State) <b>AA Co Md</b>				
24. FUNERAL DIRECTOR <b>McGully F H</b> ADDRESS <b>237 Patapsco Ave 21225</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03055

03046

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINDERMERE, MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINDERMERE, MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - 2nd Annual Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Hill</u> Last <u>Hittle</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 27 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Hill Motel</u>	9. AGE (In years last birthday) yrs. <u>64</u>
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN)</u>		14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-099783</u>	
17. INFORMANT <u>Bertha M.H. Hill-Hittle-Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gun shot wound</u> DUE TO (b) <u>knife</u> DUE TO (c) <u>stab</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>stab</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self Inflicted gun shot wound</u>		
20c. TIME OF INJURY Hour <u>3:23</u> a.m. <u>1967</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>A.A. CO. MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Joseph Hill</u>		22. DATE SIGNED <u>3/23/67</u>	
EXAMINER'S NAME (Type) <u>E. Linbrook</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Plant Haven Memorial Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Plant Haven Md.</u>
24. FUNERAL DIRECTOR <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Robert P. Singleton</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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UNITED STATES DEPARTMENT OF AGRICULTURE

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03056

## CERTIFICATE OF DEATH

03047

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>3A-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>23yrs. 8mons.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>#08325 Lulu Holt</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/84</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>16</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism(?) Carcinoma of Cecum Resection</u> (post) <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Epilepsy - Arteriosclerotic Cardiovascular Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <u>----- p.m. ----- 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/2/</u> , 19 <u>43</u> , to <u>3/9/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/9/</u> , 19 <u>67</u> , and that death occurred at <u>4:10 M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-21-67</u>		23b. DATE THEREOF <u>3-21-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>W. and M. Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>108 Wash. St. Annapolis, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAR 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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STATE OF TEXAS

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Blank document with faint horizontal lines and two punch holes on the right side.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03048

1. PLACE OF DEATH a. COUNTY <u>AA.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA.CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie - Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u> <u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A-NORTH ARUNDEL - New P.</u>		e. STREET ADDRESS <u>WASHINGTON AVE - Silby Hgts</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 13 /12</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>ARUNDEL Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>HEZIKIAH HOWARD</u>	
14. MOTHER'S MAIDEN NAME <u>VINEY SPENCER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>RUBY RICHARDSON</u> Address <u>1121 RACE ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive Cardio-vascular disease</u> DUE TO (b) <u>Sudden</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E.L. Wharoff.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>3-8-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE THEREOF <u>3-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HALL'S CHURCH CEM</u>	
23d. LOCATION (City or Town) (County) (State) <u>MARLEY NECK Md. AA.Co.</u>		24. FUNERAL DIRECTOR <u>I. L. BROWN &amp; Son</u> ADDRESS <u>123 W. MONTGOMERY ST.</u>	
25a. REC'D BY REGISTRAR <u>DATE MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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CERTIFICATE OF DEATH

03049

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PENDEENNIS Mt.</u>		c. LENGTH OF STAY IN 1b <u>22-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>RUTH L. HUSE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CADYVILLE N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LUMAN L. LAYHEE</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE FIEFIELD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>VAUGHAN H. HUSE #2</u>	
17. INFORMANT <u>VAUGHAN H. HUSE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Massive)</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arterial Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> to <u>3-28</u> , 19 <u>67</u> , that (I) <u>was</u> lost saw the deceased alive on <u>3-28</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.P. Stephens</u>		22b. DATE SIGNED <u>3-28-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D STEPHENS</u>		22d. ADDRESS <u>38 CORNHILL ST. ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "George" and "Hill" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03059					03050					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND					a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<b>ANNAPOLIS</b>					<b>ANNAPOLIS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>ANNAPOLIS NURSING HOME 2</b>					<b>104 LUCE CREEK DRIVE</b>					
3. NAME OF DECEASED (Type or print) <b>MARGUERITE E. JACKSON</b>					4. DATE OF DEATH <b>MARCH 24 1967</b>					
First Middle Last					Month Day Year					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 1, 1888</b>		9. AGE (In years last birthday) <b>78</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY			
<b>HOUSE WIFE</b>		<b>HOME</b>		<b>ANNAPOLIS MD</b>			<b>U.S.</b>			
13. FATHER'S NAME <b>JAMES A. FARRELL</b>					14. MOTHER'S MAIDEN NAME <b>CHRISTIAN LINDEN BORN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>213-22-0831</b>		17. INFORMANT <b>MARTIN T. JACKSON</b>			Address <b># 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <b>Thrombosis of inferior vena cava</b>										
DUE TO (b) <b>466X</b>										
DUE TO (c) <b>Unknown</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
<b>Paget's disease of bone</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27, 1967</b> to <b>3/24, 1967</b> , that (I) (we) last saw the deceased alive on <b>3/22, 1967</b> , and that death occurred at <b>8:45 AM</b> , from causes and on the date stated above.										
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>					22d. ADDRESS <b>59 Franklin St., Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAR. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>			23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>		
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD.</b>					ADDRESS		25a. PREP DAY REGISTRAR <b>MAR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



03020

03020

James A. Farrell	Home	Ann Arboris MD	U.S.
Female White	✓	Sept 1 1888	March 24 87
Marguerite E. Jackson			
Ann Arboris Nursing Home			
Ann Arboris			
Ann Arboris			

NO - 212-23-0821 Martin Jackson # 2

Burial March 22 1914 Cedar Bluff  
John M. Taylor and Ann Arboris MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>03060</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH</p> </div> <div> <p>03051</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				d. STREET ADDRESS <i>80 Cathedral Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>W.D.A. General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>JENKINS</i> Last <i>JENKINS</i>						4. DATE OF DEATH Month <i>3</i> Day <i>1</i> Year <i>1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-28-1903</i>		9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i> Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>MD.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Jenkins</i>						14. MOTHER'S MAIDEN NAME <i>Katie Tasker</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elizabeth Weems Anna M.</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4/20/1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary heart disease</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1/20/67</i> , 19 <i>19</i> , to <i>3/1/67</i> , 19 <i>19</i> , that (I) (we) last saw the deceased alive on <i>2/28/67</i> , 19 <i>19</i> , and that death occurred at <i>6:30 P.M.</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>E. Jenkins</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/3/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>GERMAN, CHURCH</i>						22d. ADDRESS <i>121 Cathedral St. Annapolis, Md.</i>					
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF <i>3/4/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>				23d. LOCATION (City, town or county) (State) <i>Annapolis, Md.</i>			
24. FUNERAL DIRECTOR <i>Mr. Peter H.</i>						ADDRESS <i>Annapolis, Md.</i>		25a. RECEIVED BY REGISTRAR <i>MAR 6 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



03021

03021

03021



1  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

03061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04584

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>12-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		e. STREET ADDRESS <b>Jones Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>March 19 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) <b>47</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Extreme Injuries.</b> 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>	
20c. TIME OF INJURY Month, Day, Year Hour <del>XXXX</del> <b>3/19 1967</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>A. A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		22. DATE SIGNED <b>3/20/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>City Harvest Rest</b>		23d. LOCATION (City or Town) (County) (State) <b>Severna Park St</b>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE <b>APR 18 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



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03062

## CERTIFICATE OF DEATH

03052

1. PLACE OF DEATH a. COUNTY <del>XXXXXX</del> <u>Baltimore</u> , <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN lb <u>2 days</u>		d. STREET ADDRESS <u>1819 Lansinfg Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>R.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Allis-Chalmers Mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Welder</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Flick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII 1943-45</u>		16. SOCIAL SECURITY NO. <u>304-14-2459</u>	
17. INFORMANT <u>Mr. Ivar H. Johnson (Brother)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>ASHD (arteriosclerotic heart disease)</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Any other plaque lateral sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1967</u> , to <u>March 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1967</u> , and that death occurred at <u>5:12 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>J. B. Ramirez</u>		22b. DATE SIGNED <u>3/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. B. RAMIREZ</u>		22d. ADDRESS <u>3927 ANNAPOLIS RD Balto 27</u> <u>1672 NORTH BOURNE RD Balto 12</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carmel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>La Porte, Indiana</u>
24. FUNERAL DIRECTOR <u>Eugene B. Flanning</u> <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jager</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



03005

STATE OF CALIFORNIA

03005

6000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03063

CERTIFICATE OF DEATH

03053

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>219 Holland Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>David Humphrey JOHNSTON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1921</b>
9. AGE (In years last birthday) yrs. <b>45</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M.E.L.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>David H. Johnston</b>		14. MOTHER'S MAIDEN NAME <b>Marie A. Sloma</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Ada Murch Johnston Calove</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS 2 MYOCARDIAL INFARCT</b> DUE TO (b) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>6 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(the informant)</del> attended the deceased from <b>3/20</b> , 19 <b>67</b> , to <b>March 20</b> , 19 <b>67</b> , that (I) <del>(the informant)</del> saw the deceased alive on <b>3/20</b> , 19 <b>67</b> , and that death occurred at <b>4:53 pm</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edward S. Beck</b>		22b. DATE SIGNED <b>3/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD S. BECK</b>		22d. ADDRESS <b>AA Co GEN. Hosp</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Vernon</b>	23d. LOCATION (City or town) (County) (State) <b>Bethesda, Md</b>
24. FUNERAL DIRECTOR <b>Robert S. Barranco</b>		25a. REC'D BY REGISTRAR <b>DA MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT.

03064

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH


03054

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN lb <b>Huntington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntington</b> d. STREET ADDRESS <b>042</b>	
3. NAME OF DECEASED (Type or print) <b>Waymond D. JONES</b>		4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8-33</b> 9. AGE (In years last birthday) <b>33 ?</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Roland Jones</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Skinner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> , or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-30-4512</b>	
17. INFORMANT <b>Charlotte Jones</b>		Address <b>Huntingtown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Laceration of aorta</b> DUE TO (c) <b>Blunt injury of chest</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto which ran off road while making curve</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:00</b> Hour <b>3</b> p.m. <b>31</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4-2-67</b>	
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-6-67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Patuxent Ch.Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Huntingtown Cal. Md.</b>
24. FUNERAL DIRECTOR <b>Linkey E. Seewell, Prince Fred. Md.</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03065

CERTIFICATE OF DEATH

03055

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT GEO G MEADE</b>		c. LENGTH OF STAY IN lb <b>3 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>			d. STREET ADDRESS <b>303 GEORGIA AVENUE NE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>FRANCIS</b> Last <b>KING</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 FEB 1902</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serviceman retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>JACOBS CREEK, PA</b>	
13. FATHER'S NAME <b>FRED KING</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET MOHR</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>6/24/24-6/30/65 218-36-4551</b>		17. INFORMANT <b>Emma King(wife) 303 Georgia Ave, NE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE INTO LEFT CHEST &amp; ABDOMINAL CAVITIES</b> DUE TO (b) <b>ANEURYSM OF AORTA</b> DUE TO (c) <b>ATHEROSCLEROSIS AND/OR LUES</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 Hours</b> <b>6 YEARS</b> <b>20 YEARS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>15 March</b> , 19 <b>67</b> , to <b>15 March 1967</b> , that (we) lost saw the deceased alive on <b>15 March 19 67</b> , and that death occurred at <b>4:20 M.</b> from causes on and on the date stated above.					
22a. SIGNATURE <i>Bernard T. Kravitz</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>15 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD T. KRAVITZ, CPT, MC</b>		22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>20 March 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md</b>		
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>			25a. REC'D BY REGISTRAR <b>MAR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03056

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James Albert Kirby</i>				4. DATE OF DEATH <i>3-23-1967</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-10-1910</i>	
9. AGE (In years last birthday) <i>56</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cybernetician</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Kirby</i>				14. MOTHER'S MAIDEN NAME <i>Anna Cross</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>214-05-2335</i>		17. INFORMANT <i>Mary Kirby</i> Address <i>28 Edgewood Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9299 Drawing</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> (c) <i>Sudden</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. L. Linhart</i>				22. DATE SIGNED <i>3-23-67</i>			
EXAMINER'S NAME (Type) <i>E. L. Linhart</i>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>3-28-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anna Neck</i>		23d. LOCATION (City, town or county) (State) <i>Annapolis MD</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE			
ADDRESS <i>Annapolis</i>				DATE <i>MAR 27 1967</i>			



03088

03088

*[Faint, mostly illegible handwriting covering the upper half of the page]*

*[Faint handwriting at the bottom of the page, including what appears to be a signature and some lines of text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03067

CERTIFICATE OF DEATH

03057

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>City - Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>294 West Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Katsereles LEANOS</b>				4. DATE OF DEATH Month Day Year <b>March 20, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1893.</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Greece</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>CHRIS KATSERELES</b>			
14. MOTHER'S MAIDEN NAME <b>POLYXENE KARKANES</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>JAMES S. LEANOS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO (b) <b>Perforated gastric ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left hip</b>							INTERVAL BETWEEN ONSET AND DEATH <b>chronic years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>DEAD</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell getting out of bed in a.m.</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:55 a.m. 3-14 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Annapolis Anne Arundel Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-14, 1967</b> , to <b>3-20, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-20 1967</b> , and that death occurred at <b>9:25 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Harold R Bohlman</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold R Bohlman</b>				22d. ADDRESS <b>96 Cathedral St Annapolis Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-23-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. DEMETRIUS</b>		23d. LOCATION (City or town) (County) (State) <b>Annapolis A.A. MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Lybous</b>				25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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Annapolis A.A. 170

St. Demetrius Annapolis, Md.

March 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03068

CERTIFICATE OF DEATH

03058

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>		c. LENGTH OF STAY IN Ib <i>Lifetime</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>		d. STREET ADDRESS <i>02-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anna Matilda Leatherbury</i>		4. DATE OF DEATH <i>March 22 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/26/95</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sewing</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Shadyside, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Murray Leatherbury</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Virginia Nowell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-28-6375-A</i>	
17. INFORMANT <i>Luther Leatherbury, Shadyside,</i>		Address <i>Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) <i>Complete A-V heart block</i> DUE TO (c) <i>Anterior myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>year</i> <i>year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> , 19__, to <i>March 22</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>5 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Willard F. Smith</i>		22b. DATE SIGNED <i>3/26/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Willard F. Smith, MD</i>		22d. ADDRESS <i>Shady Side, Md.</i>	
23a. BURIAL, CREMATION, or other (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3/25/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Woodfield</i>	23d. LOCATION (City or Town) (County) (State) <i>Galesville, Md.</i>
24. FUNERAL DIRECTOR <i>Bernard Hardesty Galesville, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 3 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



03058

03058

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "TO" and "FROM" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03069

CERTIFICATE OF DEATH

03059

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>1 hr. 10 min.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Crownsville</b>		d. STREET ADDRESS <b>Rt-1, Box-201</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Rose LEEDY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1895</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>67</b> Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Teel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Trade</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214187063</b>	
17. INFORMANT <b>Elizabeth Teel - Box 231 Rt 1 Severna Park</b>		Address <b>Rt 1 Severna Park</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO <b>AC-V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus + Sencarl</b> (c) <b>Diabetes mellitus + Sencarl</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> 19 <b>p.m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (has hospital) attended the deceased from <b>1957</b> , 19 <b>1967</b> , that (I) <b>saw</b> the deceased alive on <b>3-2-67</b> , 19 <b>1967</b> , and that death occurred at <b>10:25 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert R. HARR</b>		22b. DATE SIGNED <b>3/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert R. HARR</b>		22d. ADDRESS <b>Severna Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-9-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Glen Burnie A.H. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert S. Barranco</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



03050

CERTIFICATE OF DEATH

03050

DECEASED - GROUNDED

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10

1. NO. 10



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03070

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03060

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>02-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>248 Prince George St.</b>			
3. NAME OF DECEASED (Type or print) <b>"AKA" Edna Peggy Jane Lewis</b>				4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-1924</b>	9. AGE (In years lost birthday) yrs. <b>42</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b>18</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Johnstown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unk.</b>			14. MOTHER'S MAIDEN NAME <b>Unk.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Patsy Lathan</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema and prulent bronchitis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>3/5/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Weller Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Somerset Township Pa.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis, Md.</b>				25. RECEIVED BY REGISTRAR DATE <b>MAR 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John Carlos Judge</b>	



03000

03030

Jane X

AKA Jane

12-13-1924

Restaurant

Waitress

Johnstown, Pa.

Unk.

Unk.

Patsy Kathan

1416 Gloucester, N.J.  
Hillsdale, N.J.

14

Burial 3-5-1967 Weller Cemetery

Mr. M. Weller, Jr. Gloucester, N.J.

Gloucester Township, Pa.

1967



03071

CERTIFICATE OF DEATH

03061

1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>504 Harley Station Road Glen Burnie, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE DELORIS LONGAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/3/1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Richard Wafer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Daughter, 504 Harley Station Rd., Glen Burnie, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of uterus</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/21/59</u> , to <u>3/24/67</u> , that (I) (we) last saw the deceased alive on <u>3/24/67</u> , 19 <u>67</u> , and that death occurred at <u>7:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edmond I. Moushabeck</u> M.D.		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		22d. ADDRESS <u>518 Harley Station Road Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Howard H. Hubbard Funeral Home</u>		25a. REC'D BY REGISTRAR <u>27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1960

503



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**03072**

## CERTIFICATE OF DEATH

**03062**

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">3 days</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="float: right;">Anne Arundel General Hospital</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="float: right;">Maryland</span> b. COUNTY <span style="float: right;">Anne Arundel</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">RURAL - Edgewater</span> d. STREET ADDRESS <span style="float: right;">Rt-3, Box-780</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) Ella Althea MARTIN		<b>4. DATE OF DEATH</b> March 2 19 67		<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> Aug 11, 1884		<b>9. AGE</b> (In years last birthday) 82 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Prince Wm Co; Virginia		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.			
<b>13. FATHER'S NAME</b> P. J. Stevens				<b>14. MOTHER'S MAIDEN NAME</b> R. D. Stevens				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> 217-30-2417				<b>17. INFORMANT</b> Address John R. Martin, Silver Spring, Md					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. 19				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>1/11, 1965</u> , <b>to</b> <u>March 2, 1967</u> , <b>that (I) (the hospital) saw the deceased alive on</b> <u>March 2, 1967</u> , <b>and that death occurred at</b> _____ <b>M, from causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <u>Richard I. Hochman</u> M.D.										<b>22b. DATE SIGNED</b> 8:30 AM 3/3/67				<b>22c. PHYSICIAN'S NAME</b> (Type) Richard I. Hochman, M.D.				<b>22d. ADDRESS</b> 59 Franklin St., Annapolis, Md.			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> BURIAL				<b>23b. DATE THEREOF</b> March 6, 1967		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Hillcrest Cemetery				<b>23d. LOCATION</b> (City or Town) (County) (State) ANNAPOLIS, MD											
<b>24. FUNERAL DIRECTOR</b> Thomas Horobety 12 Ridgely Ave, Annapolis, Md										<b>25a. REC'D BY REGISTRAR</b> DATE MAR 7 1967				<b>25b. REGISTRAR'S SIGNATURE</b> <u>John C. Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08082

08082

MAR 7 1961



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03073

03063

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Mayo</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shoreham Beach Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Mayo</u> d. STREET ADDRESS <u>Shoreham Beach Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>F.</u> Last <u>McCarter</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Mayo, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis McCarter</u>		14. MOTHER'S MAIDEN NAME <u>Laura Merchant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Louis McCarter</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>3/1/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-4-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>	23d. LOCATION (City, town or county) (State) <u>Mayo, Md.</u>
24. FUNERAL DIRECTOR <u>John M. Saylor &amp; Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 3 1967</u>			



03003

03013

Madison Anne Arnold  
Rural - Mayo  
Shoreham Beach Rd.

Anne Arnold  
Rural - Mayo  
Shoreham Beach Road

July 17 1940 76  
Mayo, Maryland  
Kara Merchant  
Louis McCarter - #2

Male White  
x  
Boatbuilder Civil Service  
Louis McCarter  
No -



MA.

Mayo

Burial 3-4-1947 Hope Chapel  
John W. Taylor & Son, Managers, Inc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03074

CERTIFICATE OF DEATH

03064

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville/Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>16 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville,</b>		d. STREET ADDRESS <b>Rt. 2 Box 201</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carl W. McLane</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-00</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DuPont Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin McLane</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Longest</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-7809</b>	
17. INFIRMANT <b>Mrs. Catherine McLane, same as 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5271</b> DUE TO <b>Cerebrovascular Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Pulmonary Insufficiency</b> DUE TO <b>Chronic Obstructive Pulmonary Disease</b> (c) <b>Arterio-cardiac Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4.8 years</b> <b>72 days</b> <b>720 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <b>Arterio-cardiac Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-16-1967</b> to <b>10-31-1967</b> , that (I) (we) last saw the deceased alive on <b>3-31-1967</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>H. CARY T. O'NEAL</b>		22b. DATE SIGNED <b>3-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. CARY T. O'NEAL MD</b>		22d. ADDRESS <b>5 CENTRAL AVE, Glen Burnie, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3 April 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City or town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03075

CERTIFICATE OF DEATH

03065

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudley Road, West River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Sudley Road</u>	
3. NAME OF DECEASED (Type or print) <u>Craig Maurice Medley</u>		4. DATE OF DEATH <u>March 2 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Sudley Rd West River Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph M Medley</u>		14. MOTHER'S MAIDEN NAME <u>Delores Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>493X</u> (c) <u>few days (5 days)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/20/67</u> , 19 <u>67</u> , to <u>3/2/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/1/67</u> , 19 <u>67</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>3/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>House of Prayer</u>		23d. LOCATION (City or Town) (County) (State) <u>Sudley Rd West River AA</u>	
24. FUNERAL DIRECTOR <u>Bernard Hardaway</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>MAR 10 1967</u>	

7-231224



03030

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03076

CERTIFICATE OF DEATH

03066

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SUSAN CLAUDINE MEDLEY</b>		4. DATE OF DEATH Month Day Year <b>March 6 19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1882</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never worked</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John William Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Moss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-54-9726</b>	
17. INFORMANT <b>Mrs. V. Kathryn Owens - Riva, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>possible Carcinoma of Cervix</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Beverley E. Hopping</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 9, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. Md.</b>	
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> HOPPING FUNERAL HOME - Annapolis, Maryland		25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03067

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BEST GATE RD.</u>				d. STREET ADDRESS <u>BEST GATE RD.</u>			
3. NAME OF DECEASED (Type or print) <u>HARRY KAYLOR METZGER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 3 1884</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>MIDDLETOWN PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY K METZGER</u>				14. MOTHER'S MAIDEN NAME <u>FANNY CAYLOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY C METZGER #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> <u>Intermuscularis gunned</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. W. H. A. R. T.</u>				22. DATE SIGNED <u>3/29/67</u>			
EXAMINER'S NAME (Type) <u>F. L. W. H. A. R. T.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or MOVEMENT <input checked="" type="checkbox"/>		23b. DATE THEREOF <u>MAR 31, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS HA. Co. MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR Son ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



10050

0305



03078

## CERTIFICATE OF DEATH

03068

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN lb <u>1 mon. 5 das.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7 S. High Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) # <u>34472</u> First <u>Gordon</u> Middle <u>Clarence</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/33</u>
9. AGE (In years lost birthday) <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Myrtle</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome due to Chronic Alcoholism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from <u>1/29/</u> , 19 <u>67</u> , to <u>3/5/</u> , 19 <u>67</u> , that (I) (we) las saw the deceased alive on <u>3/5/</u> 19 <u>67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>W. A. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>W. A. Home Tenn.</u>
24. FUNERAL DIRECTOR <u>William Reese II 108 W WASHT ST.</u>		25a. RECD BY REGISTRAR <u>MAR 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



62060

85080



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

03079

CERTIFICATE OF DEATH

03069

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ANNAPOLIS</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RT 3 Box 357</b>		d. STREET ADDRESS <b>RT 3 Box 357</b>	
3. NAME OF DECEASED (Type or print) <b>L U L A M A E M O B E C K E R</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 13 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ZANESVILLE OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>UNKN</b>		14. MOTHER'S MAIDEN NAME <b>ALLIE KARNES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>ALBERT J. MOBECKER</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>334X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his) (her) (the) (hospital) attended the deceased from <b>4/15, 1962</b> , to <b>3/1, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/20, 1967</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b>		22b. DATE SIGNED <b>3/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>FEB 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST Mem. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS AALG MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR, SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



03008

03008

Paul Arnold

Rocky Mountain

Box 325

Lula

Female White

Housewife

Wm

No

Howard

Rocky Mountain

Box 325

Max Moscher

Feb 13 1888

San Francisco

Alie Kerner

Albert J. Moscher

THE UNIVERSITY OF CHICAGO PRESS

CHICAGO, ILL., U.S.A.

1917

THE UNIVERSITY OF CHICAGO PRESS

CHICAGO, ILL., U.S.A.

1917

THE UNIVERSITY OF CHICAGO PRESS

CHICAGO, ILL., U.S.A.



03080

CERTIFICATE OF DEATH

03070

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>11 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nursing Home</i>		d. STREET ADDRESS <i>Rt 2, Box 27</i>	
3. NAME OF DECEASED (Type or print) <i>Rodney Downing Moore</i>		4. DATE OF DEATH Month <i>3</i> Day <i>9</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/7/77</i>
9. AGE (In years and birthday) yrs. <i>89</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>PHARMACIST</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Drugs</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Chardon, Ohio</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>George E. Moore</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Downing</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>565-14-3620</i>		17. INFORMANT <i>Robert Brian M.A</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4330 CARDIAC + RESPIRATORY ARREST</i> DUE TO (b) <i>Generalized atherosclerosis</i> DUE TO (c) <i>stating the underlying cause lost.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/18</i> , 19 <i>67</i> , to <i>3/9/67</i> , that (I) (we) last saw the deceased alive on <i>2/18</i> , 19 <i>67</i> , and that death occurred at <i>7:35 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>R. Brien</i>		22b. DATE SIGNED <i>3/9/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. BIERN</i>		22d. ADDRESS <i>Annapolis Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>3-11-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST. MARGARETS</i>	23d. LOCATION (City or Town) (County) (State) <i>ST. MARGARETS A.D. MD.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor Sons Annapolis Md</i>		25a. REC'D BY REGISTRAR <i>13</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03070

CENTRAL OF DEATH

03080

Pharmacist  
Judy  
11/17/77  
More  
88  
010

no no

St. Margaret's 8-11-77 St. Margaret's



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03081					03071									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <i>Anne Arundel</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Clearwater Beach</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md. 21226</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none</i>					d. STREET ADDRESS <i>8128 Parkway</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First <i>Pearl</i> Middle <i>Morgan</i> Last <i>Morgan</i>			Month <i>March</i> Day <i>10</i> Year <i>1967</i>			Female			White					
7. MARRIED			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. UNDER 1 YEAR					
NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			November 15, 1886			80 yrs.			Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
<i>housewife</i>			<i>none</i>			<i>Baltimore, Md.</i>			<i>U.S.A.</i>					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
<i>Philip Myers</i>					<i>Virginia Gregory</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT				
<i>no</i>					<i>none</i>					<i>Mrs. Regina Atwell</i> Address <i>same</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral hemorrhage</i>										<i>1 week</i>				
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral arteriosclerosis</i>										<i>2 years</i>				
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<i>none</i>														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)					
Month, Day, Year			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						(State)					
Hour a.m. p.m.														
19														
21. I certify that (I) (this hospital) attended the deceased from <i>November 15, 1949</i> , to <i>March 10, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 9, 1967</i> , and that death occurred at <i>2:45</i> M., from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
<i>R.M. McLaughlin</i>										<i>3/10/67</i>				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
<i>R.M. McLaughlin</i>										<i>3208 Mountain Rd. Pasadena, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)						
<i>Burial</i>			<i>Mar. 13, 1967</i>		<i>Baltimore Cemetery</i>			<i>Baltimore, Maryland</i>						
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
ADDRESS					DATE									
<i>George J. Gonce- 4001 Ritchie Hgwy., Baltimore</i>					<i>MAR 13 1967</i>					<i>J. Charles Judge</i>				



03071

03081

George J. Zander - 1001 Atlantic Ave., Baltimore  
MAR 13 1967  
J. Zander



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03082

CERTIFICATE OF DEATH

03072

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>1 month</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Waterford Road Rt. 4, Box 85</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Marie MULLIGAN</b>		4. DATE OF DEATH Month Day Year <b>March 17 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 28, 1913</b>
9. AGE (In years last birthday) yrs. <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John E. Kriss</b>		14. MOTHER'S MAIDEN NAME <b>Anne B</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Carol Mulligan</b>		Address <b>— Above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>15 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrenous Cholelithiasis &amp; Gastric ulcer</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 25</b> , 19 <b>55</b> , to <b>Mar 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 17</b> , 19 <b>67</b> , and that death occurred at <b>1:10 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>S. Borssuck</b>		22b. DATE SIGNED <b>3/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. BORSSUCK</b>		22d. ADDRESS <b>A.A.G. Gen. Hosp. Annapolis A.A. Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	23d. LOCATION (City or town) (County) (State) <b>Glen Burnie A.A. Md</b>
24. FUNERAL DIRECTOR <b>Robert S. Barranco</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



08080

08080

1:10 P.M.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03083

CERTIFICATE OF DEATH

03073

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>12-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>7609 Marcy Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Terry Lynn NASH</b>		4. DATE OF DEATH Month Day Year <b>March 20 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1956</b>
9. AGE (In years last birthday) yrs. <b>10</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Donald T. Nash</b>		14. MOTHER'S MAIDEN NAME <b>Vada Shipe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Donald T. Nash, 7609 Marcy Drive, Glen Burnie</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hepatic necrosis</b> 580X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>undetermined</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 'a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> , 19 <b>67</b> , to <b>3/20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>67</b> , and that death occurred at <b>8:53 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>3-21-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-24-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Md</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



03073

COPIES OF DEED

03073

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03084

## CERTIFICATE OF DEATH

03074

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b ////////		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena (Lake Shore)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>			d. STREET ADDRESS <b>Rt. # 7 Box #168</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>H A R O L D</b> Middle <b>C.</b> Last <b>NUSBAUM</b>			4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1916 May 31, 1917</b>		9. AGE (In years last birthday) <b>50.49</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery-Ward</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wilbur Nusbaum</b>			14. MOTHER'S MAIDEN NAME <b>Helan Woodruff</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>4201 577-03-8384</b>		17. INFORMANT <b>Mrs. Henryette E. Nusbaum (wife) #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>2 YRS.</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>62</b> to <b>MARCH</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>FEB 24</b> , 19 <b>67</b> , and that death occurred at <b>4:45 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Arthur Lankford Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD, JR., M. D.</b>		22d. ADDRESS <b>2934 Mountain Rd Pasadena, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03034

03034

Name		Address		City		State		Zip	
John Doe		123 Main St		New York		NY		10001	
Age		Sex		Race		Religion		Marital Status	
35		Male		Caucasian		Protestant		Married	
Education		Occupation		Income		Assets		Liabilities	
High School		Teacher		\$15,000		\$50,000		\$20,000	
Health		Mental		Social		Family		Community	
Good		Stable		Active		Supportive		Involved	
Hobbies		Interests		Skills		Talents		Achievements	
Reading		Golfing		Teaching		Writing		Award	
References		Comments		Notes		Observations		Recommendations	
Dr. Smith		Mr. Jones		Mrs. White		Mr. Brown		Ms. Green	
Positive		Concern		Stress		Anxiety		Depression	
Stable		Unstable		Dependent		Independent		Responsible	
Compliant		Non-compliant		Cooperative		Uncooperative		Resistant	
Helpful		Unhelpful		Friendly		Unfriendly		Hostile	
Caring		Indifferent		Empathetic		Lacking empathy		Selfish	
Responsible		Irresponsible		Organized		Disorganized		Careless	
Reliable		Unreliable		Trustworthy		Untrustworthy		Deceptive	
Honest		Dishonest		Sincere		Insincere		Manipulative	
Kind		Cruel		Gentle		Harsh		Aggressive	
Patient		Impatient		Calm		Anxious		Nervous	
Flexible		Rigid		Adaptable		Inflexible		Stubborn	
Open-minded		Close-minded		Curious		Uninterested		Apathetic	
Creative		Conventional		Innovative		Traditional		Conservative	
Energetic		Lethargic		Motivated		Demotivated		Apathetic	
Optimistic		Pessimistic		Positive		Negative		Cynical	
Confident		Insecure		Assertive		Passive		Submissive	
Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
Resilient		Fragile		Tough		Soft		Weak	
Strong		Weak		Powerful		Powerless		Helpless	
Capable		Incapable		Competent		Incompetent		Ineffective	
Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
Well-groomed		Poorly-groomed		Neat		Messy		Sloppy	
Polite		Impolite		Respectful		Disrespectful		Rude	
Friendly		Unfriendly		Nice		Mean		Cruel	
Kind		Unkind		Gentle		Harsh		Aggressive	
Patient		Impatient		Calm		Anxious		Nervous	
Flexible		Rigid		Adaptable		Inflexible		Stubborn	
Open-minded		Close-minded		Curious		Uninterested		Apathetic	
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Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
Resilient		Fragile		Tough		Soft		Weak	
Strong		Weak		Powerful		Powerless		Helpless	
Capable		Incapable		Competent		Incompetent		Ineffective	
Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
Well-groomed		Poorly-groomed		Neat		Messy		Sloppy	
Polite		Impolite		Respectful		Disrespectful		Rude	
Friendly		Unfriendly		Nice		Mean		Cruel	
Kind		Unkind		Gentle		Harsh		Aggressive	
Patient		Impatient		Calm		Anxious		Nervous	
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Strong		Weak		Powerful		Powerless		Helpless	
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Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
Well-groomed		Poorly-groomed		Neat		Messy		Sloppy	
Polite		Impolite		Respectful		Disrespectful		Rude	
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Strong		Weak		Powerful		Powerless		Helpless	
Capable		Incapable		Competent		Incompetent		Ineffective	
Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
Well-groomed		Poorly-groomed		Neat		Messy		Sloppy	
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Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
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Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
Resilient		Fragile		Tough		Soft		Weak	
Strong		Weak		Powerful		Powerless		Helpless	
Capable		Incapable		Competent		Incompetent		Ineffective	
Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
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Polite		Impolite		Respectful		Disrespectful		Rude	
Friendly		Unfriendly		Nice		Mean		Cruel	
Kind		Unkind		Gentle		Harsh		Aggressive	
Patient		Impatient		Calm		Anxious		Nervous	
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Energetic		Lethargic		Motivated		Demotivated		Apathetic	
Optimistic		Pessimistic		Positive		Negative		Cynical	
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Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
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Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
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Optimistic		Pessimistic		Positive		Negative		Cynical	
Confident		Insecure		Assertive		Passive		Submissive	
Self-reliant		Dependent		Independent		Interdependent		Co-dependent	
Resilient		Fragile		Tough		Soft		Weak	
Strong		Weak		Powerful		Powerless		Helpless	
Capable		Incapable		Competent		Incompetent		Ineffective	
Efficient		Inefficient		Productive		Unproductive		Wasteful	
Organized		Disorganized		Neat		Messy		Sloppy	
Clean		Dirty		Tidy		Untidy		Slovenly	
Well-groomed		Poorly-groomed		Neat		Messy		Sloppy	
Polite		Impolite		Respectful		Disrespectful		Rude	
Friendly		Unfriendly		Nice		Mean		Cruel	
Kind		Unkind		Gentle		Harsh		Aggressive	
Patient		Impatient		Calm		Anxious		Nervous	
Flexible		Rigid		Adaptable		Inflexible		Stubborn	
Open-minded		Close-minded		Curious		Uninterested		Apathetic	
Creative		Conventional		Innovative		Traditional		Conservative	
Energetic		Lethargic		Motivated		Demotivated		Apathetic	



03085

## CERTIFICATE OF DEATH

03075

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 yr. 10 mos.</u>		d. STREET ADDRESS <u>511 S. Collington Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>#29558 Lucyle</u> First <u>Lucya</u> Middle <u>Soph</u> Last <u>Ogrodowczyk</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/84</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-7052</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Hypostatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pyelitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1967</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/20/1965</u> , to <u>3/17/1967</u> , that (I) (we) last saw the deceased alive on <u>3/17/1967</u> , and that death occurred at <u>1:55 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>		22b. DATE SIGNED <u>3/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/20/67</u>		23b. DATE THEREOF <u>3/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. WEBER &amp; SONS INC. 401 S. CHESTER ST.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4590

1994



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03086

CERTIFICATE OF DEATH

03076

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>11 months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Ranier</b>		d. STREET ADDRESS <b>3105 Queens Chapel Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vincent</b> Middle <b>F.</b> Last <b>O'Neill</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9 February 1887</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer-ornamental</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Bryan I. O'Neill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kleckner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b> <b>W.W. I</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records, Anne Arundel General Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular insufficiency</b> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerosis, general, cardiac, cerebral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>more than 1 year</b> <b>? years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus, Benign prostatic hypertrophy, Uremia, Pulmonary emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 April</b> , 19 <b>66</b> , to <b>3 March</b> , 19 <b>67</b> that (I) (we) lost saw the deceased alive on <b>3 March</b> , 19 <b>67</b> , and that death occurred at <b>8:20 P</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>4 March, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Beverly E. Hopping</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 7 1967</b>	
HOPPING FUNERAL HOME <b>- Annapolis, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



122080



03087

CERTIFICATE OF DEATH

03077

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ma ryland</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rivier a Beach</b> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel General Hospital</b>		d. STREET ADDRESS <b>8439 Church Road</b>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>L.</b> Last <b>PARR</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Messenger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Equitable Trust</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME ---		14. MOTHER'S MAIDEN NAME ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>053-03-8176</b>	
17. INFORMANT <b>Mrs. Helen Parr</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertension</b> DUE TO (c) <b>Cardiac failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>67</b> , to <b>3/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/7/67</b> 19 <b>67</b> , and that death occurred at <b>9:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Dabolins</b>		22b. DATE SIGNED <b>3/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Dabolins M. D.</b>		22d. ADDRESS <b>400 Crain Hwy. N. W. Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Maryland</b>
24. FUNERAL DIRECTOR <b>George J. Gonce</b>		25a. REG'D BY REGISTRAR <b>4001 Ritchie Hwy. (21225)</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 13 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7750

18030

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



03088

## CERTIFICATE OF DEATH

03078

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>27 yrs. 3 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>		d. STREET ADDRESS <b>1720 E. Capitol Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Randall</b> Middle <b>Robert</b> Last <b>Robert</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-27</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	9. AGE (In years last birthday) yrs. <b>39</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Orlon Randall</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Randall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Children's Center Hospital, Laurel, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephrosclerosis</b> DUE TO <b>Acute gastric distention</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Softening of 9th thoracic certerbrae - possible neorplast</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Jan. 1967</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Moderate degree of cirrhosis - (suspect)</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 7, 19 39</b> , to <b>March 25, 19 67</b> , that (I) (we) last saw the deceased alive on <b>March 25, 19 67</b> , and that death occurred at <b>4:40pM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James E. Boyland</b>		22b. DATE SIGNED <b>3/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES E. BOYLAND, M. D.</b>		22d. ADDRESS <b>Children's Center, Laurel, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/31/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Children's Center</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel A. A. Md.</b>
24. FUNERAL DIRECTOR <b>William H. Randall</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
ADDRESS <b>Laurel Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08078

EXHIBIT 0-10-10

08088

1. Name of the person or organization		2. Address	
3. City		4. State	
5. Zip		6. Telephone	
7. Date		8. Signature	
9. Title		10. Organization	
11. Purpose of visit		12. Other information	
13. Name of the person or organization		14. Address	
15. City		16. State	
17. Zip		18. Telephone	
19. Date		20. Signature	
21. Title		22. Organization	
23. Purpose of visit		24. Other information	
25. Name of the person or organization		26. Address	
27. City		28. State	
29. Zip		30. Telephone	
31. Date		32. Signature	
33. Title		34. Organization	
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619. Date		620. Signature	
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657. Title		658. Organization	
659. Purpose of visit		660. Other information	
661. Name of the person or organization		662. Address	
663. City		664. State	
665. Zip		666. Telephone	
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669. Title		670. Organization	
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715. Date		716. Signature	
717. Title		718. Organization	
719. Purpose of visit		720. Other information	
721. Name of the person or organization		722. Address	
723. City		724. State	
725. Zip		726. Telephone	
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735. City		736. State	
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779. Purpose of visit		780. Other information	
781. Name of the person or organization		782. Address	
783. City		784. State	
785. Zip		786. Telephone	
787. Date		788. Signature	



FOR STATE  
HEALTH DEPT.

03089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03079

1. PLACE OF DEATH a. COUNTY <u>HACO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North. ARUNDEL</u>		d. STREET ADDRESS <u>104 Ralph. Road.</u>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>E</u> Last <u>Randozza</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-08</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Practice</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Kenneth Rocker</u>	
14. MOTHER'S MAIDEN NAME <u>Goldie (Unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>068-18-6070</u>		17. INFORMANT <u>PAUL RANDOZZO - Same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>3-1-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4 Mar 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn A.C. Md.</u>
24. FUNERAL DIRECTOR <u>Singleton Funeral Home / Glen Burnie</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



090730

030330

WAR 2 8AM



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03090

## CERTIFICATE OF DEATH

03080

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>Box 112-B Rt. 2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>N.</u> Middle <u>Ray</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-92</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, XXXXXXXXXXXX, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Nunn</u>	
14. MOTHER'S MAIDEN NAME <u>Jessie Hamilton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Willis A. Ray, Sr., same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerotic heart disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>anuria - uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>58</u> to <u>March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-19-</u> 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C.R. MacDonald M.D.</u>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. C.R. MacDonald</u>		22d. ADDRESS <u>P.O. Box 700, Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>22 March 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel Co., Md.</u>
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08080

08080

NAME		DATE	
FATHER		MOTHER	
BORN		DIED	
PLACE		PLACE	
CITY		CITY	
STATE		STATE	
COUNTRY		COUNTRY	
RELIGION		RELIGION	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIAGE		MARRIAGE	
CHILDREN		CHILDREN	
SIBLINGS		SIBLINGS	
PARENTS		PARENTS	
GRANDPARENTS		GRANDPARENTS	
OTHER RELATIVES		OTHER RELATIVES	
FRIENDS		FRIENDS	
ACQUAINTANCES		ACQUAINTANCES	
NEIGHBORS		NEIGHBORS	
TEACHERS		TEACHERS	
EMPLOYERS		EMPLOYERS	
OTHER		OTHER	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03081**

**03091**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>A.A. Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MAGO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNA POLIS</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.H. - Anne Arundel. Gen.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C.</b> Last <b>REINERT</b>				4. DATE OF DEATH Month <b>3</b> Day <b>11</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-11-12</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b> Hours <b>11</b> Min.	IF UNDER 24 HRS. Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BOAT YARD.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>William Reinert</b>			
14. MOTHER'S MAIDEN NAME <b>Esther Gabbler</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates at service)			
16. SOCIAL SECURITY NO. <b>A605971A</b>				17. INFORMANT Address <b>Alone</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Deceleration</b> <b>4344</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stroke</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. L. Howard</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. L. Howard</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>3-14-67</b>		<b>Epiphany Cem.</b>		<b>Adenton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert S. Barranco</b>				24a. REC'D BY REGISTRAR <b>MAR 16 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



19020

TECO

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



03092

## CERTIFICATE OF DEATH

03082

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN lb <b>1 day</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Arnold</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-1, Box-345</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TERESA</b> Middle <b>ANNE</b> Last <b>RICKERT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1967</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>2</b> Days <b>30</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John F. Rickert</b>				14. MOTHER'S MAIDEN NAME <b>May K. Hanlon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>7635</b>		17. INFORMANT <b>John F. Rickert - Above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-17</b> , 19 <b>67</b> , to <b>3-18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-18</b> , 19 <b>67</b> , and that death occurred at <b>3:20 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Clayton Norton</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>				22d. ADDRESS <b>Severna Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda National</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethesda Md.</b>	
24. FUNERAL DIRECTOR <b>Robert A. Banana, Severna Park, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



\$8050

52520



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03093

## CERTIFICATE OF DEATH

03083

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1910 West Street</b>			d. STREET ADDRESS <b>1910 West Street</b>		
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>PARKER</b> Last <b>SAVOY</b>			4. DATE OF DEATH Month <b>March</b> Day <b>31-</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16-1892</b>	9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co, Maryland</b>		
13. FATHER'S NAME <b>Gabriel Parker</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Martha Ann Cole</b>		
16. SOCIAL SECURITY NO. <b>212-18-0980 A</b>			17. INFORMANT <b>Dorothy Savoy-1910 West St. Anna. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X</b> DUE TO <b>Pneumonia Heart Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Hypertension and Varicose Veins</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6-23-59</b> , 19....., to <b>3-31-67</b> , 19....., that (I) (we) last saw the deceased alive on <b>3-24-67</b> , 19....., and that death occurred at <b>3-31-67</b> , 19....., from the causes and on the date stated above.					
22a. SIGNATURE <b>Faye Allen</b>			22b. DATE SIGNED <b>APR 5 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Faye Allen</b>			22d. ADDRESS <b>62 Cathedral St. Annapolis, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>April 3-67</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>			23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks</b>			25a. REC'D BY REGISTRAR <b>APR 5 1967</b>		
ADDRESS <b>111 Annapolis, Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



68086

62050

100

5015-35

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
03094		CERTIFICATE OF DEATH	
03084			
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>12-1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>Box 1 Revell Highway Rt. 4,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Carroll SCOTT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1881</b>
9. AGE (In years lost, birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> IF UNDER 24 HRS. Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>SALES MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL FURNITURE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Wm H. SCOTT</b>		14. MOTHER'S MAIDEN NAME <b>MARY VIRGINIA PATRICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>MRS. MILDRED S. CUTLER # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>2 Wk</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benzoin Thoracic Hypertrophy</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-9-67</b> , to <b>3-22-1967</b> that (I) (we) last saw the deceased alive on <b>3-22-1967</b> , and that death occurred at <b>12:30 P.M.</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>F.M. SHIPLEY</b>		22b. DATE SIGNED <b>3-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. SHIPLEY</b>		22d. ADDRESS <b>ANNAPOLIS MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-25-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. MARGARETS Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>St. MARGARETS A.A. Co. MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



1908

STATE OF DEATH

1908

Wm H. Scott	2122 May	State Furniture	Harvard
Mrs Virginia Patrick			
Mrs Mildred S. Cutler #2			

*[Faint, illegible handwriting and text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03095

CERTIFICATE OF DEATH

03085

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KNOLLWOOD Nursing HOME</u>		d. STREET ADDRESS <u>114 BEST GATE RD.</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDE</u> <u>VIRGINIA</u> <u>SEXTON</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1888</u>
9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JESSIE F. SEARS</u>		14. MOTHER'S MAIDEN NAME <u>ROSIE LEE TROTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>EVELYN S. ADAMS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>urina</u> DUE TO (b) <u>acute &amp; chronic pyelonephritis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>probable pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>—</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R.M. Smith</u>		22b. DATE SIGNED <u>3-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.M. SMITH</u>		22d. ADDRESS <u>SEVERNA PARK MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EDWARDS CHAPEL</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



08085

A.A.

MD.

Annapolis

111 Best Gate Rd.

Section

10-20-1888 78

Maryland

Rosie Lee Trotter

Evelyn S. Adams #2

08085

A.A.

Millersville

Knollwood Nursing Home

Maryland

Virginia

X

W

F

Honolulu

Honolulu

Jessie F. Sears

—

no

3-1-17

MD

Severna Park

R.M. Smith

Chapel Annapolis A.A. MD

3-11-67

Edwards Chapel, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03096					03086				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Anne Arundel			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Annapolis			11 hrs.		Mayo				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?	
Anne Arundel General Hospital					214 Maryland Ave.,			YES <input type="checkbox"/> NO <input type="checkbox"/>	
					Beverly Beach			12/1	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		Month		Day
First Middle Last					SHERZEY		Margh		Year
Otto William							7		19 67
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 29, 1917		50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Meat Cutter						Washington, D.C.		U.S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William B. Sherzey					Emma Nordhorff				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No					Isabel A. Sherzey		Same As # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								12 HRS	
IMMEDIATE CAUSE (a) Massive U. cerebral embolus?								life	
332X DUE TO (b) Pulm. stenosis (marked); tricuspid insufficiency; intervent. septal defect									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Unbridled aorta									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 3/7, 1967, to 3/7, 1967, that (I) (we) last saw the deceased alive on 3/7, 1967, and that death occurred at 11:02 P.M. from causes on and the date stated above.									
22a. SIGNATURE						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
Peter F. Verkouw								3/7/67	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
Peter F. Verkouw, M.D.						1407 Forest Drive, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 10, 1967		Cedar Hill Cemetery		Prince Georges, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wilhelm Funeral Home, 4308 Suitland Road, Suitland, Md.						MAR 10 1967		Charles Judge	







FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65



03087

03087



MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]  
[The following text is mirrored and largely illegible due to the quality of the scan and bleed-through from the reverse side of the page.]



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03098

Items #8 & 9 Film #G3873/29/67 pc

CERTIFICATE OF DEATH

03088

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Box 302A, Solley &amp; Opal Rds.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanor Castlel Simmons</b>				4. DATE OF DEATH <b>March 18 1967</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1887</b>	
9. AGE (In years last birthday) <b>82 79</b> rs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cook (ret)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Y.M.C.A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Beanscove, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Daniel Castael</b>				14. MOTHER'S MAIDEN NAME <b>Merthe Donohue</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>John W. <del>Simmons</del> Simmons(husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>congestion heart failure</b> DUE TO (c) <b>arteriosclerotic cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 14</b> , 19 <b>67</b> , to <b>Mar. 18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Mar. 18</b> , 19 <b>67</b> , and that death occurred at <b>8:20 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Ray M. Smith</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar. 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ray M. Smith M. D.</b>				22d. ADDRESS <b>Hahn Professional Bldg., Severna Pk., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>22 March 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ceder Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brooklyn, Maryland</b>	
24. FUNERAL DIRECTOR <b>R.V. Singleton</b> ADDRESS <b>Singleton Funeral Home/Glen Burnie, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08088

08088

STATE OF OHIO

COOK (T-1)

BRANDON, R.

General Counsel

Unknown

John E. Ransom (Assistant)

BOYD, RICHARD LOVELL

STOCKY, RAYMOND

STOCKY, RAYMOND

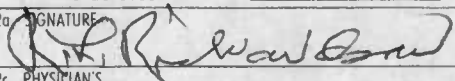
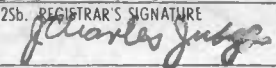
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03099					03099					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9 Pleasant Court</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>9 Pleasant Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William NMN Simms</b>					4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>8-12-1902</b>		9. AGE (In years last birthday) <b>64</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pantryman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>			11. BIRTHPLACE (County & State, or foreign country) <b>A.A.Co Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Simms</b>					14. MOTHER'S MAIDEN NAME <b>Mary Miller</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No *****</b>			16. SOCIAL SECURITY NO. <b>215-16-7179</b>		17. INFORMANT <b>Elizabeth Simms 9 Pleasant Court</b> Address <b>Annapolis, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Lungs, Liver and Stomach</b> DUE TO (b) <b>1992</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1966</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>October 1966</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>October</b> , 19 <b>66</b> , to <b>Mar. 11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Mar. 11</b> , 19 <b>67</b> , and that death occurred at <b>7A.M.</b> from causes on and on the date stated above.										
22a. SIGNATURE 					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>March 11, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>RAYMOND L. RICHARDSON, M.D.</b>					22d. ADDRESS <b>110 Clay Street, Annapolis</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-15-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>			23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A.Co Md</b>			
24. FUNERAL DIRECTOR <b>Hicks' Funeral Home</b>					ADDRESS <b>45 Northwest Street</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1967</b>		25b. REGISTRAR'S SIGNATURE 	



03033

John S. James

4

CM 100, 0, A California

92-21-2



## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 03100 CERTIFICATE OF DEATH 03091

<b>1. PLACE OF DEATH</b> a. COUNTY <div style="text-align: center;">Anne Arundel MARYLAND</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <div style="text-align: center;">Maryland</div> b. COUNTY <div style="text-align: center;">Anne Arundel</div>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Ft Geo G. Meade, Maryland</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center;">10 days</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Pasadena</div>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center;">Kimbrough AH, Ft Geo G. Meade, Md.</div>				d. STREET ADDRESS <div style="text-align: center;">308 Sharon Drive</div>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center;">Edgar O. Smith</div>		<b>4. DATE OF DEATH</b> Month Day Year <div style="text-align: center;">March 2 1967</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <div style="text-align: center;">Male</div>	6. COLOR OR RACE <div style="text-align: center;">Cau</div>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center;">June 7, 1917</div>	9. AGE (In years last birthday) <div style="text-align: center;">49 yrs.</div>	IF UNDER 1 YEAR Months Days 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Retired US Army</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Civil Service</div>		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">Baltimore, Maryland</div>			
13. FATHER'S NAME <div style="text-align: center;">William Smith</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Agatha Leibaugh</div>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center;">Yes 1942-1960</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">216-01-6230</div>		17. INFORMANT <div style="text-align: center;">308 Sharon Drive Madeleine Smith(W) Pasadena, Maryland</div>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <div style="text-align: center;">582X Acute Pancreatitis</div> DUE TO (b) <div style="text-align: center;">Pylephlebitis</div> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">1 week</div>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center;">19</div>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from 22 February, 1967, to 2 March, 1967, that (we) last saw the deceased alive on 2 March, 1967, and that death occurred at 1:18 AM, from the causes and on the date stated above.							
22a. SIGNATURE <div style="text-align: center;">Howard M. Tanning</div>		22b. DATE <div style="text-align: center;">2 March 1967</div>		22c. PHYSICIAN'S NAME (Type) <div style="text-align: center;">HOWARD M. TANNING, CPT, MC</div>			
22d. ADDRESS <div style="text-align: center;">Kimbrough Army Hospital, Ft G.M. Meade, Md.</div>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		23b. DATE THEREOF <div style="text-align: center;">6 March 67</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Lorraine Park</div>			
23d. LOCATION (City, town or county) (State) <div style="text-align: center;">Baltimore, Md.</div>							
24. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center;">Kirkley Funeral Home, Glen Burnie, Md.</div>							
25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <div style="text-align: center;">Charles Judge</div>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03100

03094

CENTINATE OF CLASH

James C. and Maryland in 1895

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Maryland

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03101

CERTIFICATE OF DEATH

03092

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u>				c. LENGTH OF STAY IN b. <u>1-18-67 to 3-26-67</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>108 Hedclaw Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>NMN</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-1896</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>		9b. KIND OF BUSINESS OR INDUSTRY		10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHANIEL Smith</u>				14. MOTHER'S MAIDEN NAME <u>MARIA NEAL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>CORINA HAWKINS-1980 WST ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO <u>Compound Fracture, Secondary Osteomyelitis; 1 1/2 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Senility</u> (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-18-1967</u> to <u>3-26-1967</u> , that (I) (we) last saw the deceased alive on <u>3-24-1967</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>				22d. ADDRESS <u>100 Cherry Lane, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. HICKS III</u>				ADDRESS <u>ANNAPOLIS, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03102

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03093

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Route 4, Box 59				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Mary Smith				4. DATE OF DEATH Month Day Year 3 24 1967									
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-96		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY @ home				11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-36-9607		17. INFORMANT Patient's chart		Address - Hosp Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 158x Shock DUE TO (b) Peritoneal carcinomatosis DUE TO (c) Ovarian tumor												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 23, 1967, to March 24, 1967, that (I) (we) last saw the deceased alive on March 23, 1967, and that death occurred at 5:30 M, from the causes and on the date stated above.													
22a. SIGNATURE J. B. Ramirez				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3/24/67					
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ				22d. ADDRESS 3527 ANNAPOLIS RD Balto 27 1672 N. H. Ave Balto 12									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
Burial		3/27/67		Hawthorne		Dorsey Md.							
24. FUNERAL DIRECTOR Robert S. Barranco				ADDRESS Severna Park				25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03094

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>5 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>A.A.Cty Cent.Hqtrs.Police Station Millersville</b>				d. STREET ADDRESS <b>Rt 5, Box 82, Carroll Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Melvin Sparkman, Jr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/26</b>	9. AGE (In years last birthday) yrs. <b>41</b>	10. IF UNDER 1 YEAR Months <b>18</b> Days <b>19</b> Hours <b>67</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Melvin Sparkman Sr</b>				14. MOTHER'S MAIDEN NAME <b>Gola Mae Hochett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII Korean 2/19/1930</b>		16. SOCIAL SECURITY NO. <b>219101930</b>		17. INFORMANT <b>Virginia L. Sparkman - Alone</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hung himself with his belt</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1</b> p.m. <b>3/18</b> 19 <b>67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cell block</b>		20f. (City or town) (County) (State) <b>Millersville, A.A., Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz MD.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>March 19, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-22-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel National</b>		23d. LOCATION (City or town) (County) (State) <b>Bethel City Md</b>	
24. FUNERAL DIRECTOR <b>Robert S. Barranco</b>				25a. REC'D BY REGISTRAR <b>Severna Park, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

ROBERT S. BARRANCO

MAR 27 1967



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03104 CERTIFICATE OF DEATH 03095

1. PLACE OF DEATH a. CDUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Naval Hospital, Annapolis, Md.		c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) PASADENA d. STREET ADDRESS RT 10 Box 86C e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH March 22 1967	
5. SEX Female	6. CILDR DR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 March 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) 13 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.	
13. FATHER'S NAME William H. SPEAS		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT (Mother) Mrs. Irene Speas, Rt. 10, Box 86-C, Pasadena, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Prematurity 32 hours INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-21-67 to 3-22, 1967, that (I) (we) last saw the deceased alive on 3-22 1967, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE C. H. Dandrey		22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) U.S. NAVAL HOSPT. ANNAPOLIS MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-24-67	
23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		23d. LOCATION (City, town or county) (State) Annapolis MD.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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03104  
[illegible]

Allyson  
Pamela  
Rita Lee

Naval Hospital, Annapolis, Md.

Baby Girl

Conc.

21 March 1957

Annapolis, Md.

William H. Sears

Trans. 405

(Subject)  
Mrs. Irene Sears, Ac. 1, Box 86-C, Annapolis, Md.

*Handwritten signature*

U.S. Naval Hospital, Annapolis, Md.

3-21-57  
Wm. H. Sears  
Annapolis, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03105

CERTIFICATE OF DEATH

03096

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>02-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>18 N. Cherry Grove Ave.,</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Helen P. (none) STALLINGS</b>		4. DATE OF DEATH Month Day Year <b>March 22 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1881</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM O. PERRY</b>		14. MOTHER'S MAIDEN NAME <b>SALLY CRANDALL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ROBERT STALLINGS # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>--</b> DUE TO (c) <b>--</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia, heart failure, post-op sigmoid colon cancer resect, Arteriosclerosis, and dorsal kyphoscoliosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(did not)</del> attended the deceased from <b>Mar 27</b> , 19 <b>67</b> , to <b>Mar. 22</b> , 19 <b>67</b> , that (I) <del>(we)</del> saw the deceased alive on <b>March 22, 1967</b> , and that death occurred at <b>4:30 AM</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>Mar 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, MD</b>		22d. ADDRESS <b>South RivMedCent., Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-14-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JAMES CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>TRACYS LNDG. ARLG. MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR, SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



John M. Tinkering Announces MD

BURIAL 3-24-1917 ST James Cem

Travis Lane H&C MD.

No —

William O. Perry

Home

Garry Chandler

Robert Stallings # 2

03036

03107



03106

CERTIFICATE OF DEATH

03097

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>3</b> years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Manor Nursing Home</b>		d. STREET ADDRESS <b>Glen Burnie, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Lillian Rumpf STANSBURY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 1, 1894</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ba.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Karl Rumpf</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219 16 1912</b>	
17. INFORMANT <b>Carolyn Carter - Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> 526X DUE TO <b>Pulmonary emphysema and fibrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Bronchitis acute &amp; chronic, and bronchiectasis</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis, general, cardiac and cerebral; Diabetes mellitus; Pseudobulbar palsy, Chronic pyelonephritis; Multiple myeloma; Hypertension; Scurvy; Anemia.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>many years</b> <b>many years</b> <b>many years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 30, 1965</b> , to <b>March 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1967</b> , and that death occurred at <b>4:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>March 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/8/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial Ch Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Millersville, Md.</b>
24. FUNERAL DIRECTOR <b>Robert P. Ware</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1967</b>	
ADDRESS <b>Singleton Funeral Home/Glen Burnie, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03208

03208

STATE OF OHIO

County of Franklin, ss. I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.

Witness my hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

Attest: My hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

Witness my hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

Attest: My hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

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Witness my hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

Attest: My hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.

Witness my hand and the seal of the Court at Columbus, Ohio, this 1st day of March, 1908.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03098

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1055 NORMAN DR APT 107</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Apartment Americana - Monroe Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE E. STONE</b>		4. DATE OF DEATH <b>Pronounced March 31, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 17, 1892</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>HALIFAX PENN.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>THEODORE ETTER</b>		14. MOTHER'S MAIDEN NAME <b>MARY BRUBAKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>ST 1223 RD.</b>	
17. INFORMANT <b>MRS. JAMES R. HOLST</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Carbon Monoxide</b> DUE TO (c) <b>Conflagration</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in burning apartment</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:00 p.m. 3-30- 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>house</b>		20f. (City or town) (County) (State) <b>Annapolis Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		22. DATE SIGNED <b>March 31, 1967</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE THEREOF <b>4-4-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WHITEMARSH MEM. CEM.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Horsesham, Montgomery, Pa.</b>		24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR - SONS ANNAPOLIS MD</b>	
25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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1. *Introduction*

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Exp. 10000 10000

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• G. N. ... ..



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03108

## CERTIFICATE OF DEATH

03099

1. PLACE OF DEATH a. COUNTY <u>Crownville State Hospital</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownville</u> c. LENGTH OF STAY IN lb <u>08-2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownville St. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> d. STREET ADDRESS <u>Crownville Md.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>SWEETNEY</u> Middle <u>William</u> Last 4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1967</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-8-1916</u> 9. AGE (In years last birthday) yrs. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>nil</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Charles Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Charles Co, Md.</u>	
13. FATHER'S NAME <u>ALBERT D. SWEETNEY</u>		14. MOTHER'S MAIDEN NAME <u>LORREY SWEETNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Sweetney-Bryantown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE FAILURE, hyper-tension.</u> DUE TO <u>stroke, brain. oedema.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chorea</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>7/23/64</u> , 19 <u>64</u> , to <u>3/16/67</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>3/16/67</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. BENEDICT MD</u>		22b. DATE SIGNED <u>3/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT MD</u>		22d. ADDRESS <u>Crownville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Ch. Cemetery Bryantown Char. Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Bryantown Char. Md.</u>	
24. FUNERAL DIRECTOR <u>Matell Adams Aquasco, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10150

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03109

## CERTIFICATE OF DEATH

03100

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Barbara Ellen TASSEY</b>		4. DATE OF DEATH Month Day Year <b>March 2 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1911</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher school</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Curtis</b>		14. MOTHER'S MAIDEN NAME <b>Maudie McNamee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217388311</b>	
17. INFORMANT <b>Mr. Arthur G. Tasse, alone</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Shutdown</b> <b>4331</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Multiple embolism of General &amp; Peripheral</b> DUE TO <b>Arterial Fibrillation</b> (c) <b>myocardial heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1958</b> , to <b>Mar. 2, 1967</b> that (I) (we) saw the deceased alive on <b>March 2, 1967</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert R. Hahn</b> M.D.		22b. DATE SIGNED <b>3-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert R. Hahn, M.D.</b>		22d. ADDRESS <b>Box-73, Severna Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		23d. LOCATION (City or town) (County) (State) <b>Ft. Det. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert S. Barancko, Severna Park, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 6 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03109

06120



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03110

CERTIFICATE OF DEATH

03101

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAY MARGARETS</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> 02-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>				d. STREET ADDRESS <u>109 CHARLES ST.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES C. TAYLOR</u> First Middle Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1884</u>	9. AGE (In years last birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL FOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>CHARLES W. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>JANE NICHOLS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>JOHN TAYLOR 8 STEELE AVE ANNAP. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/22, 1966</u> to <u>3/1, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/1, 1967</u> , and that death occurred at <u>8:55 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD I. HOCHMAN</u>				22d. ADDRESS <u>59 FRANKLIN ST ANNAPOLIS MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-4-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS AACo MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, SON ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR OATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within \_\_\_\_\_ hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03110

CENTRAL OF MICHIGAN

03101

James Anderson

27th Street

For information please see my card 27

Charles O. Taylor

4-4-1904 32

Next door to Taylor's

Charles W. Taylor

born 1904

James Taylor & Sons - Furniture

27th Street

1904

27th Street

James W. Taylor & Sons - Furniture  
27th Street  
4-4-1904  
born 1904



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03111

## CERTIFICATE OF DEATH

03102

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>27 days</u>		d. STREET ADDRESS <u>216 Bridgeview Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) # <u>34560</u> First <u>Theresa</u> Middle <u>Johnson</u> Last <u>Tellington</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-24</u>
9. AGE (In years last birthday) yrs. <u>42</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Whitmire, S.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joe H. Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Estelle Epps</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-20-7325</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Acute Renal Failure</u> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Malignant Hypertension?</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic - Depressive Psychosis, Extreme Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>2/8/</u> , 19 <u>67</u> , to <u>3/7/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/7/</u> 19 <u>67</u> , and that death occurred at <u>8:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Md.</u>
24. FUNERAL DIRECTOR <u>Morton &amp; Dyett F.H.</u>		25a. REC'D BY REGISTRAR <u>1701 Laurens St.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>MAR 9 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03112

## CERTIFICATE OF DEATH

03103

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>H.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>430 2ND ST.</b>		d. STREET ADDRESS <b>430 2ND ST.</b>	
3. NAME OF DECEASED (Type or print) <b>EDNA M. THOMAS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	9. AGE (In years last birthday) yrs. <b>66</b>
11. BIRTHPLACE (County & State, or foreign country) <b>PHILA, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>TRUEMAN BOISSEAU</b>		14. MOTHER'S MAIDEN NAME <b>MARIE HEALEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>EDNA M. BOWEN #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma pancreas</b> DUE TO (b) <b>Metastatic adenocarcinoma lymph nodes unknown</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. <b>3-16</b> 19 <b>67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-16</b> , 19 <b>67</b> , to <b>3-16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-16</b> , 19 <b>67</b> , and that death occurred at <b>3:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W.P. Stephens</b>		22b. DATE SIGNED <b>3-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.P. Stephens</b>		22d. ADDRESS <b>38 Cornhill Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF <b>3-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis MD.</b>
24. FUNERAL DIRECTOR <b>John M. Layton &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05113  
A.A.

MD

A.A.

THOMAS  
1-14-1901  
FILA, Pa.  
Marie Harey  
EDNA M BOWEN #2

Horsewitz

EDNA  
F W  
Home  
TREMAN BOISEAN  
no

ST. Marys  
3-20-67  
MAR 2 1967  
Auna Boris  
MAR 2 1967



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03113

## CERTIFICATE OF DEATH

03104

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>1028 Pennsylvania Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>#34926 Howard Lee Thomas</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/19/35</u>
9. AGE (In years lost birthday) <u>32 yrs.</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>67</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Thornton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Alcoholic Intoxication, Delirium Tremens</u> DUE TO 307X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema, Severe Fatty Metamorphosis of Liver</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year <u>Hour am</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>3/17/</u> , 19 <u>67</u> , to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/20/</u> 19 <u>67</u> , and that death occurred at <u>9:30 A.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>A A County Md</u>
24. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. DATE <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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03104

5420



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03114

CERTIFICATE OF DEATH

03105

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>8 hrs. 10 min</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt. 1, Box 52</b>	
3. NAME OF DECEASED (Type or print) <b>Edwin Moore</b>		4. DATE OF DEATH March 12 1967	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1904</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RET</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>JOHN I. TUCKER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA V. WELLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>ANN BRADY TUCKER</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150x Car carcinoma &amp; cerebral aneurysms</b> DUE TO (b) <b>192.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>Mar 11 1967</b> to <b>Mar 12 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>Mar 11 1967</b> , and that death occurred at <b>3:50 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Gene D. Trettin</b>		22b. DATE SIGNED <b>3/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gene D. Trettin, M.D.</b>		22d. ADDRESS <b>98 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, RENEWAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-15-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Lyons</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
25a. DATE <b>MAR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



03105

03110

Civil Service  
John I Tucker  
Ret  
Emma V. Wells  
Ann Brady Tucker #2

ST Mary's  
Annapolis, Md  
3-15-67

Annapolis, Md



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03115

## CERTIFICATE OF DEATH

03106

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Cty</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing Home</u>		d. STREET ADDRESS <u>826 Jenice Dr. Annapolis</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD A. TURNER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman-Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman-Applicant Charles Co. Ind.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Ira Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>412-01-2849 A</u>	
17. INFORMANT <u>Mrs Mildred Turner</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repeated "Small" strokes</u> DUE TO (b) <u>Severe generalized and brain Art. scler. C.V. Dis. 2 years</u> (c) <u>Question of terminal malignancy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old massive lt. sided CVA. Atrial Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-26</u> , 19 <u>66</u> , to <u>3/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/15/11</u> 1967, and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Peter F. Verkouw</u>		22b. DATE SIGNED <u>3/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER F. VERKOUW</u>		22d. ADDRESS <u>1407 Fordot Drive Annapolis</u>	
23a. BURIAL, CREMATION, RMP (Specify)	23b. DATE THEREOF <u>3-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis Md.</u>		25a. REC'D BY REGISTRAR <u>15 MAR 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03108

CERTIFICATE OF DEATH

03115

Enlist 2-12-17  
Hillcrest  
Hillcrest A. H. Co.



FOR STATE  
HEALTH DEPT.

03116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03107

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AACO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KERSH.</u>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville - MD. 02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North. PRINCE OF L - Hosp.</u>		d. STREET ADDRESS <u>146 DOCKSER DRIVE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph.</u> Middle <u>M.</u> Last <u>Waldron</u>	4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1931</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Waldron</u>	
14. MOTHER'S MAIDEN NAME <u>O'Donnell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>182-24-1999</u>		17. INFORMANT <u>Faye Waldron</u> Address <u>146 Dockser Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.0</u> DUE TO <u>Acute alcoholic intoxication</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Acute alcoholic intoxication</u> (c) <u>Acute alcoholic intoxication</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>313/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of The Fields</u>	23d. LOCATION (City or town) (County) (State) <u>Millersville, Md.</u>
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>		25a. REC'D BY REGISTRAR <u>MAR 7 1967</u>	
Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



03103

03103

1987 MAR 7



03117

CERTIFICATE OF DEATH

03108

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		d. STREET ADDRESS <b>4 DEWEY DRIVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b> <del>XXXXXXXXXX</del> <b>T. WANAT</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 MARCH 1920</b>
9. AGE (In years lost birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ANALYST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SERVICE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GARWOOD, NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DMYTRO WANAT</b>		14. MOTHER'S MAIDEN NAME <b>ANNA KUFTA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Oct 39 - Apr 59</b>		16. SOCIAL SECURITY NO. <b>154-01-5904</b>	
17. INFORMANT <b>Betty E. Wanat, Ellicott City, Md</b>		18. ADDRESS <b>4 Dewey Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Coronary Arteriosclerosis</b> DUE TO (b) <b>Suspicious Acute Myocardial Infarction (Pending</b> DUE TO (c) <b>microscopic exam)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XXXXXXXXXX</del> the deceased <del>XXXX</del> WAS DOA <del>XXXX</del> <b>24 MARCH 1967</b> <del>XXXXXXXXXX</del> <del>XXXXXXXXXX</del> <b>4:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>John M. Adams</i>		22b. DATE SIGNED <b>24 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN M. ADAMS, CPT, MC</b>		22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 29 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <i>W.C. Higgins</i>		25a. REC'D BY REGISTRAR <b>MAR 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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UNITED STATES OF AMERICA

CHIEF

CLERK

RECORDS

UNITED STATES

DEPARTMENT OF

INTERNAL SECURITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03118					03109					
1. PLACE OF DEATH a. CDUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, 21226</i>			c. LENGTH OF STAY IN 1b <i>39 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Orchard Beach 02-1</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none</i>					d. STREET ADDRESS <i>7926 East End Drive</i>			e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>George Noble Watkins</i>					4. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1967</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>November 18, 1883</i>		9. AGE (In years last birthday) <i>83 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>glass blower</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Summell Bros.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George N. Watkins, Sr.</i>					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>212-10-8260</i>		17. INFORMANT <i>Mrs. Geo Watkins</i>			Address <i>Same address</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary arteriosclerotic heart disease</i> DUE TO (c) <i>Essential hypertension</i>								INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>3 weeks</i> <i>10 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>October 2, 1944</i> to <i>March 4, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 4, 1967</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.										
22a. SIGNATURE <i>R.M. McLaughlin</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/4/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					22d. ADDRESS <i>3708 Mountain Rd. Pikesville, Md 21222</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>3/7/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>		23d. LOCATION (City, town or county) (State) <i>A A Co Md</i>			
24. FUNERAL DIRECTOR <i>McCully F H</i>					ADDRESS <i>237 Patapsco Ave 21225</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 7 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



03118

03118





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03113

03110

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>7 1/2 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt#1 Box 409</b>	
3. NAME OF DECEASED (Type or print) <b>George (none)</b>		4. DATE OF DEATH Month <b>3</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3-97</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George White</b>		14. MOTHER'S MAIDEN NAME <b>Siddie Hoanney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 4/24/18-12/3/18</b>		16. SOCIAL SECURITY NO. <b>218-14-3440</b>	
17. INFORMANT <b>Amanda White Severna Park</b>		18. ADDRESS <b>Severna Park</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DIS.</b> DUE TO (c) <b>UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from <b>24 MARCH, 19 67</b> to <b>March 24, 19 67</b> , that (I) (we) saw the deceased alive on <b>March 24, 19 67</b> , and that death occurred at <b>7:00 P.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Edward S. Beck</b>		22b. DATE SIGNED <b>3/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck M.D.</b>		22d. ADDRESS <b>373 Franklin St. Annapolis, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carpenters Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Severna Park P.A. Md</b>
24. FUNERAL DIRECTOR <b>Johnnie's Funeral Home Annapolis, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 29 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03110

03110

Time of arrival

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

Time of departure

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March 1957

March 1957

March 1957

March 1957

March 1957

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03120

CERTIFICATE OF DEATH

03111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hosp.</u>		d. STREET ADDRESS <u>107 CHARLES ST.</u>	
3. NAME OF DECEASED (Type or print) <u>George Wells WHITE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	9. AGE (In years last birthday) yrs. <u>72</u>
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH A. WHITE</u>		14. MOTHER'S MAIDEN NAME <u>MARY WINDSOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>214 05 0873</u>	
17. INFORMANT <u>HELENE P. WHITE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> DUE TO (b) <u>5271</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 26</u> , 19 <u>67</u> , and that death occurred at <u>9 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FOREST DR. ANNAPOLIS, MD.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



03111

03120

George 11/13

H. C. W.

City of New York

Joseph H. White

First Assistant

Yes, we are, and others believe so.

Robinson and his family

the children

George H. C. W.

First Assistant



03121

## CERTIFICATE OF DEATH

03112

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>	
c. LENGTH OF STAY IN lb <b>10 days</b>		d. STREET ADDRESS <b>Rt. #3 Box 99B</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #34947 <b>Lora Whites</b>		4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/1887</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harve Dills</b>		14. MOTHER'S MAIDEN NAME <b>Stidman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>254-40-0367</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardio-Vascular Accident</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Senility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <b>----- 1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from <b>3/18/67</b> , to <b>3/27/67</b> , that (I) (we) last saw the deceased alive on <b>3/27/67</b> , and that death occurred at <b>3:30 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp</b>		22b. DATE SIGNED <b>3/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>30 March 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 30 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03118

RECEIVED BY MAIL

03118

APR 30 1981



03122

CERTIFICATE OF DEATH

03113

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i> c. LENGTH OF STAY IN b. <i>7 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Glaziers Manor 355 Glaziers Rd. Catonsville, Baltimore Co., Md.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville, Baltimore Co., Md.</i> d. STREET ADDRESS <i>145 Winters Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MAMIE WILLIAMS</i> First Middle Last 4. DATE OF DEATH <i>3 29 1967</i> Month Day Year				5. SEX <i>Female</i> 6. COLOR OR RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>3-16-1892</i> 9. AGE (In years last birthday) <i>75</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <i>Catonsville, Baltimore, Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>United States</i>				13. FATHER'S NAME <i>Oden Williams</i> 14. MOTHER'S MAIDEN NAME <i>Pumphrey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <i>220-34-7341</i> 17. INFORMANT <i>Patients Chart</i> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493x Coronary Failure</i> DUE TO (b) <i>Acute Pulmonary Congestion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at..... M, from the causes and on the date stated above.				22a. SIGNATURE <i>Richard H. Hunt</i> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i> 22d. ADDRESS <i>100 Cherry Lane, Glen Burnie, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>4-1-67</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Catholic Mt. Park</i> 23d. LOCATION (City, town or county) (State) <i>Catonsville, Baltimore Co., Md.</i>				24. BURIAL DIRECTOR'S SIGNATURE <i>Mrs. Frances A. Henrich</i> ADDRESS <i>57 E. Biddle St.</i> 25a. REC'D BY REGISTRAR <i>3</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> DATE <i>3 1967</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



81163

55180



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

03123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03114

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>115 SEVERN PARK</u> Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN PARK</u> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL.</u>		d. STREET ADDRESS <u>Pl 2 - Box 618</u>	
3. NAME OF DECEASED (Type or print) <u>John J.</u> First Middle Last <u>WISE Sr.</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-42</u>
9. AGE (In years lost birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Potts &amp; Callahan</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Wise</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Sarah Wise</u>		Address <u>Box 618 C, Route 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Monoxide</u> <u>9731</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None from accident into car</u>	
20c. TIME OF INJURY Hour <u>6:00</u> p.m. Month, Day, Year <u>3-4 1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>AA Co MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-8-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Lilly &amp; Zeiler Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 6 1967</u>	
ADDRESS <u>1901-07 Eastern Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03114

03113

SL

Post & Telegraph

Post & Telegraph

Post & Telegraph

Post & Telegraph

Mrs. Sarah M. Box 10, House 2

Baltimore, Maryland

Post & Telegraph

Post & Telegraph

Post & Telegraph

03114

Post & Telegraph



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03115

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOH IN HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN EARLIE WOOD</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/16/18 1898</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Dunkirk, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN WOOD</b>			
14. MOTHER'S MAIDEN NAME <b>Lillie Markquess</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>			
16. SOCIAL SECURITY NO. <b>280 094214</b>				17. INFORMANT <b>Rosie L. Wood</b> Address <b>#2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE</b> DUE TO (b) <b>CARCINOMA OF LUNG</b> DUE TO (c) <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>SEVERAL MO.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NO INJURY</b>			
21a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles H. Wirth, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>CHARLES H. WIRTH, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>LOTHIAN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>3-21-67</b>		<b>Mt. Zion</b>		<b>Mt. Zion A.A. MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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Ridger  
John Wood  
Girl Service Dunkirk, MD.  
Little Markness  
Yes was 200 of 1941 Rosie L. Wood

Revised 3-1-67 Mt Zion  
John W. Johnson Chicago, Md.

Mt Zion A.A. No.



03125

## CERTIFICATE OF DEATH

03116

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bay Manor Nursing Home</b>		d. STREET ADDRESS <b>1901 3rd. Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>K.</b> Last <b>WORMLEY</b>		4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/1875</b>
9. AGE (In years lost birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James T. Wormley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ringold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Gertrude D. Wormley</b>		Address <b>1901 3rd. Street, N.W. Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>3/25</b> , 1967, that (I) (we) last saw the deceased alive on <b>3/25</b> , 1967, and that death occurred at <b>10:50 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman, M.D.</b>		22b. DATE SIGNED <b>3/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover, Maryland</b>	
24. FUNERAL DIRECTOR <b>W. Ernest Jarvis Co.</b>		25a. REC'D BY REGISTRAR <b>1432 You Street, N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 28 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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